AM7216
LB 1248
MHF-4/10/2006

E & R AMENDMENTS TO LB 1248

Introduced by Enrollment and Review Committee: Flood, 19, Chairperson

1. Strike the original sections and all amendments thereto and insert the following new sections:

Section 1. Sections 1 to 49 of this act shall be known and may be cited as the Medical Assistance Act.

Sec. 2. The purposes of the Medical Assistance Act are to (1) reorganize and recodify statutes relating to the medical assistance program, (2) provide for implementation of the Medicaid Reform Plan, (3) clarify public policy relating to the medical assistance program, (4) provide for administration of the medical assistance program within the department, and (5) provide for legislative oversight and public comment regarding the medical assistance program.

Sec. 3. Section 68-1018, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1018 That there is hereby established in and for the State of Nebraska a program to be known as medical assistance.~~ The medical assistance program is established, which shall also be known as medicaid.

Sec. 4. The Legislature finds that (1) many low-income Nebraska residents have health care and related needs and are unable, without assistance, to meet such needs, (2) publicly funded medical assistance provides essential coverage for necessary health care and related services for eligible low-income Nebraska

AM7216
LB 1248
MHF-4/10/2006

children, pregnant women and families, aged persons, and persons with disabilities, (3) publicly funded medical assistance alone cannot meet all of the health care and related needs of all low-income Nebraska residents, (4) the State of Nebraska cannot sustain a rate of growth in medical assistance expenditures that exceeds the rate of growth of General Fund revenue, (5) policies must be established for the medical assistance program that will effectively address the health care and related needs of eligible recipients and effectively moderate the growth of medical assistance expenditures, and (6) publicly funded medical assistance must be integrated with other public and private health care and related initiatives providing access to health care and related services for Nebraska residents.

Sec. 5. It is the public policy of the State of Nebraska to provide a program of medical assistance on behalf of eligible low-income Nebraska residents that (1) assists eligible recipients to access necessary and appropriate health care and related services, (2) emphasizes prevention, early intervention, and the provision of health care and related services in the least restrictive environment consistent with the health care and related needs of the recipients of such services, (3) emphasizes personal independence, self-sufficiency, and freedom of choice, (4) emphasizes personal responsibility and accountability for the payment of health care and related expenses and the appropriate utilization of health care and related services, (5) cooperates with public and private sector entities to promote the public health, (6) cooperates with providers, public and private

employers, and private sector insurers in providing access to health care and related services and encouraging and supporting the development and utilization of alternatives to publicly funded medical assistance for such services, (7) is appropriately managed and fiscally sustainable, and (8) qualifies for federal matching funds under federal law.

Sec. 6. Section 68-1021, Revised Statutes Supplement, 2005, is amended to read:

~~68-1021~~ For ~~the purpose~~ purposes of paying medical assistance ~~as defined in~~ under the Medical Assistance Act and sections 68-1002~~,~~ and 68-1006, ~~and 68-1018 to 68-1025,~~ the State of Nebraska ~~hereby~~ accepts and assents to all applicable provisions of Title XIX and Title XXI of the federal Social Security Act. Any reference in the Medical Assistance Act to the federal Social Security Act or other acts or sections of federal law shall be to such federal acts or sections as they existed on April 1, 2006. ~~The Director of Finance and Support is authorized to adopt and promulgate rules and regulations, to enter into agreements, to adopt fee schedules with regard to medical assistance benefits, rehabilitation services, and any other remedial services, and to adopt copayments and deductibles with respect to such benefits and services if the requirements of subsection (4) of section 68-1019 are met.~~

Sec. 7. For purposes of the Medical Assistance Act:

(1) Committee means the Health and Human Services Committee of the Legislature;

(2) Department means the Department of Health and Human

Services Finance and Support;

(3) Director means the Director of Finance and Support;

(4) Medicaid Reform Plan means the Medicaid Reform Plan submitted on December 1, 2005, pursuant to the Medicaid Reform Act enacted pursuant to Laws 2005, LB 709;

(5) Medicaid state plan means the comprehensive written document, developed and amended by the department and approved by the federal Centers for Medicare and Medicaid Services, which describes the nature and scope of the medical assistance program and provides assurances that the department will administer the program in compliance with federal requirements;

(6) Provider means a person providing health care or related services under the medical assistance program; and

(7) Waiver means the waiver of applicability to the state of one or more provisions of federal law relating to the medical assistance program based on an application by the department and approval of such application by the federal Centers for Medicare and Medicaid Services.

Sec. 8. Section 68-1023, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1023 The Department of Health and Human Services Finance and Support may contract with the agencies administering in the State of Nebraska, Health Insurance for the Aged, identified as Public Law 89-97, 89th Congress, or with any other domestic agency or corporation licensed by the Department of Insurance to engage in the insurance business in the State of Nebraska, to act as fiscal agents for the Department of Health and Human Services Finance~~

~~and Support and to make payments to vendors providing medical assistance authorized under sections 68-1018 to 68-1025.~~ (1) The department shall administer the medical assistance program.

(2) The department may (a) enter into contracts and interagency agreements, (b) adopt and promulgate rules and regulations, (c) adopt fee schedules, (d) apply for and implement waivers and managed care plans for eligible recipients, and (e) perform such other activities as necessary and appropriate to carry out its duties under the Medical Assistance Act.

(3) The department shall maintain the confidentiality of information regarding applicants for or recipients of medical assistance and such information shall only be used for purposes related to administration of the medical assistance program and the provision of such assistance or as otherwise permitted by federal law.

(4)(a) The department shall prepare a biennial summary and analysis of the medical assistance program for legislative and public review, including, but not limited to, a description of eligible recipients, covered services, provider reimbursement, program trends and projections, program budget and expenditures, the status of implementation of the Medicaid Reform Plan, and recommendations for program changes.

(b) The department shall provide a draft report of such summary and analysis to the Medicaid Reform Council no later than October 1 of each even-numbered year. The council shall conduct a public meeting no later than October 15 of such year to discuss and receive public comment regarding such report. The council shall

provide any comments and recommendations regarding such report in writing to the director and the committee no later than November 1 of such year. The department shall submit a final report of such summary and analysis to the Governor, the Legislature, and the council no later than December 1 of such year.

Sec. 9. (1) All contracts, agreements, rules, and regulations relating to the medical assistance program as entered into or adopted and promulgated by the department prior to the operative date of this act and all provisions of the medicaid state plan and waivers adopted by the department prior to the operative date of this act shall remain in effect until revised, amended, repealed, or nullified pursuant to law.

(2) Prior to the adoption and promulgation of proposed rules and regulations under section 12 of this act or relating to the implementation of medicaid state plan amendments or waivers, the department shall provide a report to the Governor, the Legislature, and the Medicaid Reform Council summarizing the purpose and content of such proposed rules and regulations and the projected impact of such proposed rules and regulations on recipients of medical assistance and medical assistance expenditures.

(3) The Medicaid Reform Council, no later than thirty days after the date of receipt of any report under subsection (2) of this section, may conduct a public meeting to receive public comment regarding such report. The council shall promptly provide any comments and recommendations regarding such report in writing to the department. Such comments and recommendations shall

be advisory only and shall not be binding on the department, but the department shall promptly provide a written response to such comments or recommendations to the council.

(4) The department shall monitor and shall periodically, as necessary, but no less than biennially, report to the Governor, the Legislature, and the Medicaid Reform Council on the implementation of rules and regulations, medicaid state plan amendments, and waivers adopted under the Medical Assistance Act and the effect of such rules and regulations, amendments, or waivers on eligible recipients of medical assistance and medical assistance expenditures.

Sec. 10. Section 68-1022, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1022~~ **Except** ~~for care in a state institution and care on behalf of persons who have a right of residence on any reservation under the jurisdiction of the government of the United States, the cost of medical assistance paid by the county in which the recipient may have a legal settlement shall be eighteen percent commencing July 1, 1979. Commencing July 1, 1985, the county shall pay four and sixty-seven hundredths percent of the cost of such medical assistance. Commencing July 1, 1986, and thereafter, medical assistance shall be paid from state funds and such funds as may be allocated by the government of the United States. The liability for payment of medical services shall be determined based on the date the services are rendered.~~ (1) Medical assistance shall be paid from General Funds, cash funds, federal funds, and such other funds as may qualify for federal matching funds under federal

law. General Fund appropriations for the program shall be based on an assessment by the Legislature of General Fund revenue and the competing needs of other state-funded programs.

(2) Medical assistance paid on behalf of eligible recipients may include, but is not limited to, (a) direct payments to vendors under a fee-for-service, managed care, or other provider contract, (b) premium payments, deductibles, and coinsurance for private health insurance coverage, employer-sponsored coverage, catastrophic health insurance coverage, or long-term care insurance coverage, and (c) payments to providers who serve eligible recipients of medical assistance or low-income uninsured persons and meet federal and state disproportionate-share payment requirements.

(3) Medical assistance shall not be paid directly to eligible recipients.

Sec. 11. Section 68-1019, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1019~~ (1) Medical assistance shall include coverage for health care and related services as required under Title XIX of the federal Social Security Act, including, but not limited to: ~~On behalf of recipients shall be paid directly to vendors.~~

~~(2) On behalf of recipients over sixty-five years of age, medical assistance shall include care in an institution for mental diseases.~~

~~(3) On behalf of all recipients, medical assistance shall include:~~

(a) Inpatient and outpatient hospital ~~care~~ services;

(b) Laboratory and X-ray services;

(c) Nursing ~~home~~ facility services;

~~(d) Care home services;~~

~~(e)~~ (d) Home health ~~care~~ services;

~~(f)~~ (e) Nursing services;

~~(g)~~ (f) Clinic services;

(g) Physician services;

(h) Medical and surgical services of a dentist;

(i) Nurse practitioner services;

(j) Nurse midwife services;

(k) Pregnancy-related services;

(l) Medical supplies; and

(m) Early and periodic screening and diagnosis and treatment services for children.

~~(h) Services of practitioners licensed by the Department of Health and Human Services Regulation and Licensure; and~~

~~(i) Such drugs, appliances, and health aids as may be prescribed by practitioners licensed by the Department of Health and Human Services Regulation and Licensure.~~

~~(4) The Department of Health and Human Services Finance and Support shall adopt and promulgate rules and regulations to establish a schedule of premiums, copayments, and deductibles for goods and services provided under the medical assistance program. Such schedule shall discourage abuse of high-cost services and encourage the utilization of cost-effective services. Prior to the adoption of the schedule of copayments and deductibles, the department shall provide a report to the Governor and the~~

~~Legislature outlining proposed copayments and deductibles. The report shall collect and summarize available data from other states concerning their experience with copayments and deductibles, determine if vendors may be reimbursed for copayments and deductibles resulting from a recipient's inability to pay, evaluate the collectability of copayments and deductibles, and assess the effect of copayments and deductibles on recipients, vendors, access to and availability of care, and utilization of affected medical assistance program services. The report shall include data from Nebraska as it becomes available. The report shall also provide information as to other cost-containment mechanisms which have been implemented or proposed by the department for the fiscal year. If the department is proposing to adopt a schedule, the report shall be provided to the Governor and the Legislature by December 1. No schedule of copayments and deductibles shall be put into effect until July 1 following the report, except that for the first year the schedule shall be put into effect by April 1. If the department is proposing elimination or modification of an existing schedule of copayments and deductibles, a report on the proposed changes shall be provided to the Governor and the Legislature by December 1. The proposed modification or elimination of the schedule of copayments and deductibles shall not take place prior to the July 1 following this report. Vendors shall be responsible for collecting any applicable copayment or deductible from the recipient.~~

~~(5) The Department of Health and Human Services Finance and Support shall adopt and promulgate rules and regulations to provide limits as to the amount, duration, and scope of goods~~

~~and services recipients may receive under the medical assistance program. Prior to the adoption of such rules and regulations, the department shall provide a report to the Governor and the Legislature outlining proposed limits. Such report shall be provided to the Governor and the Legislature by December 1. No rules or regulations to implement such limits shall be put into effect until April 1 following the report.~~

~~(6) No vendor shall advertise or promote through newspapers, magazines, circulars, direct mail, directories, radio, television, or otherwise that such vendor will waive the collection of all or any portion of any copayment or deductible established pursuant to subsection (4) of this section.~~ (2) Medical assistance may include coverage for health care and related services as permitted but not required under Title XIX of the federal Social Security Act, including, but not limited to:

(a) Prescribed drugs;

(b) Intermediate care facilities for the mentally retarded;

(c) Home and community-based services for aged persons and persons with disabilities;

(d) Dental services;

(e) Rehabilitation services;

(f) Personal care services;

(g) Durable medical equipment;

(h) Medical transportation services;

(i) Vision-related services;

(j) Speech therapy services;

(k) Physical therapy services;

(l) Chiropractic services;

(m) Occupational therapy services;

(n) Optometric services;

(o) Podiatric services;

(p) Hospice services;

(q) Mental health and substance abuse services;

(r) Hearing screening services for newborn and infant children; and

(s) Administrative expenses related to administrative activities, including outreach services, provided by school districts and educational service units to students who are eligible or potentially eligible for medical assistance.

Sec. 12. Section 68-1019.01, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1019.01 (1) In developing the proposed limits as to amount, duration, and scope of services and goods recipients may receive under the medical assistance program, the Director of Finance and Support shall consider the effect such limits will have on the ability of such recipients to maintain their health, to live independently outside of medical institutions, and to engage in employment. The director shall also consider the impact such limits will have on short-term and long-term savings of expenditures to the medical assistance program.~~

~~(2) The director shall include in the report required under section 68-1019 the philosophy, standards, and criteria used to develop the proposed limits for amount, duration, and scope~~

~~taking into consideration the criteria outlined in subsection (1) of this section and any other criteria as may be determined by the director.~~ (1) The department may establish (a) premiums, copayments, and deductibles for goods and services provided under the medical assistance program, (b) limits on the amount, duration, and scope of goods and services that recipients may receive under the medical assistance program, and (c) requirements for recipients of medical assistance as a necessary condition for the continued receipt of such assistance, including, but not limited to, active participation in care coordination and appropriate disease management programs and activities.

(2) In establishing and limiting coverage for services under the medical assistance program, the department shall consider (a) the effect of such coverage and limitations on recipients of medical assistance and medical assistance expenditures, (b) the public policy in section 5 of this act, (c) the experience and outcomes of other states, (d) the nature and scope of benchmark or benchmark-equivalent health insurance coverage as recognized under federal law, and (e) other relevant factors as determined by the department.

(3) Coverage for mandatory and optional services and limitations on covered services as established by the department prior to the operative date of this act shall remain in effect until revised, amended, repealed, or nullified pursuant to law. Any proposed reduction or expansion of services or limitation of covered services by the department under this section shall be subject to the reporting and review requirements of section 9 of

AM7216
LB 1248
MHF-4/10/2006

this act.

(4) Except as otherwise provided in this subsection, proposed rules and regulations under this section relating to the establishment of premiums, copayments, or deductibles for eligible recipients or limits on the amount, duration, or scope of covered services for eligible recipients shall not become effective until the conclusion of the earliest regular session of the Legislature in which there has been a reasonable opportunity for legislative consideration of such rules and regulations. This subsection does not apply to rules and regulations that are (a) required by federal or state law, (b) related to a waiver in which recipient participation is voluntary, or (c) proposed due to a loss of federal matching funds relating to a particular covered service or eligibility category. Legislative consideration includes, but is not limited to, the introduction of a legislative bill, a legislative resolution, or an amendment to pending legislation relating to such rules and regulations.

Sec. 13. Section 68-1025.01, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1025.01~~ (1) Each public school district shall annually, at the beginning of the school year, provide written information supplied by the Department of Health and Human Services and the Department of Health and Human Services Finance and Support to every student describing the availability of children's health services provided under the medical assistance program. ~~established under sections 68-1018 to 68-1025.~~

(2) Each hospital shall provide the mother of every

child born in such hospital, at the time of such birth, written information provided by the ~~Director of Health and Human Services and the Director of Finance and Support~~ departments describing the availability of children's health services provided under the medical assistance program. ~~established under sections 68-1018 to 68-1025.~~

(3) The ~~Director of Health and Human Services and the Director of Finance and Support~~ departments shall develop and implement other activities designed to increase public awareness of the availability of children's health services provided under the medical assistance program. ~~These activities may include, but need not be limited to, public service announcements, the development and distribution of printed materials describing the program, periodically locating agency staff at public sites outside the Department of Health and Human Services offices for the purpose of receiving applications for the program, contracting with organizations in order to assist the public to apply for program benefits and to receive referrals for medical services as deemed necessary, and other activities deemed appropriate by the directors. These~~ Such activities shall include materials and efforts designed to increase participation in the program by minority populations.

Sec. 14. An applicant for medical assistance shall file an application with the department in a manner and form prescribed by the department. The department shall notify an applicant for or recipient of medical assistance of any decision of the department to deny or discontinue eligibility or to deny or modify medical

assistance. Decisions of the department, including the failure of the department to act with reasonable promptness, may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Sec. 15. Section 68-1020, Revised Statutes Supplement, 2005, is amended to read:

~~68-1020 (1) Medical assistance shall be paid on behalf of (a) dependent children~~ The following persons shall be eligible for medical assistance:

(1) Dependent children as defined in section 43-504;

(2) Aged, ~~(b) aged,~~ blind, and disabled persons~~,~~ as defined in sections ~~43-504 and~~ 68-1002 to 68-1005; ~~, and (c) all persons less than nineteen~~

(3) Children under nineteen years of age who are eligible under section 1905(a)(i) of the federal Social Security Act; ~~.~~

~~(2) The Department of Health and Human Services Finance and Support shall adopt and promulgate rules and regulations governing provision of such medical assistance benefits to qualified persons:~~

~~(a) Who~~ (4) Persons who are presumptively eligible as allowed under sections 1920 and 1920B of the federal Social Security Act;

~~(b) Who have~~ (5) Children under nineteen years of age and pregnant women with a family income equal to or less than one hundred eighty-five percent of the Office of Management and Budget income poverty guideline, as allowed under Title XIX and Title XXI of the federal Social Security Act, without regard to

AM7216
LB 1248
MHF-4/10/2006

resources. ~~,~~ ~~including all children under nineteen years of age and pregnant women as allowed under 42 U.S.C. 1396a, and section 2110 of the federal Social Security Act.~~ Children described in this subdivision and subdivision (6) of this section shall remain eligible for six consecutive months from the date of initial eligibility prior to redetermination of eligibility. The department may review eligibility monthly thereafter pursuant to rules and regulations adopted and promulgated by the department. ~~Such rules and regulations shall specify the nature of such reviews and the information upon which such reviews will be based and shall require the consideration of variations in family income and other relevant factors in conducting such reviews.~~ The department may determine upon such review that a child is ineligible for medical assistance ~~benefits~~ if such child no longer meets eligibility standards established by the department; ~~.~~ ~~All children currently eligible on August 16, 2002, shall have their initial period of continuous eligibility reduced to six months and shall have their eligibility redetermined pursuant to subsection (5) of this section and subdivision (1)(s) of section 68-1713. Beginning on August 16, 2002, the department shall report to the Legislature and the Governor on a quarterly basis until November 3, 2003, and each December 1 thereafter through December 1, 2005. The report shall include, but shall not be limited to, the number of monthly reviews conducted, the number of children determined to be ineligible under this subdivision, and demographic information concerning the reviews, including family income, county of residence, ages of children, and reasons for ineligibility;~~

~~(c) Who, for~~ (6) For purposes of Title XIX of the federal Social Security Act as provided in subdivision ~~(b)~~ (5) of this ~~subsection~~ section, ~~are~~ children ~~in families~~ with a family income as follows:

~~(i)~~ (a) Equal to or less than one hundred fifty percent of the Office of Management and Budget income poverty guideline with eligible children one year of age or younger;

~~(ii)~~ (b) Equal to or less than one hundred thirty-three percent of the Office of Management and Budget income poverty guideline with eligible children over one year of age and under six years of age; or

~~(iii)~~ (c) Equal to or less than one hundred percent of the Office of Management and Budget income poverty guideline with eligible children six years of age or older and less than nineteen years of age; ~~or~~

~~(d) Who~~ (7) Persons who are medically needy caretaker relatives as allowed under 42 U.S.C. 1396d(a)(ii); ~~.~~

~~(3)~~ (8) As allowed ~~pursuant to~~ under 42 U.S.C. 1396a(a)(10)(A)(ii), ~~medical assistance shall be paid on behalf of~~ disabled persons as defined in section 68-1005 ~~who are in families whose net~~ with a family income ~~is~~ of less than two hundred fifty percent of the Office of Management and Budget income poverty guideline ~~applicable to a family of the size involved~~ and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be receiving federal Supplemental Security Income. The Department of Health and Human Services shall apply for a waiver to disregard any unearned income

that is contingent upon a trial work period in applying the Supplemental Security Income standard. Such disabled persons shall be subject to payment of premiums as a percentage of ~~the family's net~~ family income beginning at not less than two hundred percent of the Office of Management and Budget ~~net~~ income poverty guideline. Such premiums shall be graduated based on family income and shall not be less than two percent or more than ten percent of family ~~net~~ income; and ~~.~~

~~(4)~~ (9) As allowed ~~pursuant to~~ under 42 U.S.C. 1396a(a)(10)(A)(ii), ~~medical assistance shall be paid on behalf of~~ persons who:

(a) Have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act, 42 U.S.C. 300k et seq., in accordance with the requirements of section 1504 of such act, 42 U.S.C. 300n, and who need treatment for breast or cervical cancer, including precancerous and cancerous conditions of the breast or cervix;

(b) Are not otherwise covered under creditable coverage~~,~~ as defined in section 2701(c) of the federal Public Health Service Act, 42 U.S.C. 300gg(c);

(c) Have not attained sixty-five years of age; and

(d) Are not eligible for ~~medicaid~~ medical assistance under any mandatory categorically needy eligibility group.

~~(5)~~ Eligibility shall be determined under this section using an income budgetary methodology that determines children's

eligibility at no greater than one hundred eighty-five percent of the Office of Management and Budget income poverty guideline and adult eligibility using adult income standards no greater than the applicable categorical eligibility standards established pursuant to state or federal law. The department shall ~~redetermine~~ determine eligibility under this section pursuant to such income budgetary methodology and subdivision (1)(s) of section 68-1713.

~~(6) The department shall adopt and promulgate rules and regulations to implement this section.~~

Sec. 16. Section 68-1026, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1026~~ The application for medical assistance ~~benefits under sections 68-1018 to 68-1025~~ shall constitute an automatic assignment of the rights specified in this section to the ~~Department of Health and Human Services Finance and Support~~ department or its assigns effective from the date of eligibility for such ~~benefits~~ assistance. The assignment shall include the rights of the applicant or recipient and also the rights of any other member of the assistance group for whom the applicant or recipient can legally make an assignment.

Pursuant to this section and subject to sections ~~68-1038 to 68-1043~~ 21 to 25 of this act, the applicant or recipient shall assign to the department or its assigns any rights to medical care support available to him or her or to other members of the assistance group under an order of a court or administrative agency and any rights to pursue or receive payments from any third party liable to pay for the cost of medical care and services arising

AM7216
LB 1248
MHF-4/10/2006

out of injury, disease, or disability of the applicant or recipient or other members of the assistance group which otherwise would be covered by medical assistance. ~~benefits.~~ Medicare benefits shall not be assigned pursuant to this section. ~~Benefits~~ Rights assigned to the department or its assigns ~~by operation of~~ under this section may be directly reimbursable to the department or its assigns by liable third parties, as provided by rule or regulation of the department, when prior notification of the assignment has been made to the liable third party.

Sec. 17. Section 68-1027, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1027~~ Refusal by the applicant or recipient specified in section ~~68-1026~~ 16 of this act to cooperate in obtaining reimbursement for medical care or services provided to himself or herself or any other member of the assistance group renders the applicant or recipient ineligible for assistance. Ineligibility shall continue for so long as such person refuses to cooperate. Cooperation may be waived by the ~~Department of Health and Human Services Finance and Support~~ department upon a determination of the reasonable likelihood of physical or emotional harm to the applicant, recipient, or other member of the assistance group if the applicant or recipient were to cooperate. Eligibility shall continue for any individual who cannot legally assign his or her own rights and who would have been eligible for assistance but for the refusal by another person, legally able to assign such individual's rights, to cooperate as required by this section.

Sec. 18. Section 68-1028, Reissue Revised Statutes of

Nebraska, is amended to read:

~~68-1028~~ If the applicant or recipient or any member of the assistance group becomes ineligible for medical assistance, ~~benefits,~~ the ~~Department of Health and Human Services Finance and Support~~ department shall restore to him or her the rights assigned under section ~~68-1026~~ 16 of this act.

Sec. 19. Section 68-1036.02, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1036.02~~ (1) The recipient of medical assistance ~~benefits~~ under the medical assistance program ~~established under section 68-1018~~ shall be indebted to the ~~Department of Health and Human Services Finance and Support~~ department for the total amount paid for medical assistance on behalf of the recipient if:

(a) The recipient was fifty-five years of age or older at the time the medical assistance was provided; or

(b) The recipient resided in a medical institution and, at the time of institutionalization or application for medical assistance, whichever is later, the department determines that the recipient could not have reasonably been expected to be discharged and resume living at home. For purposes of this section, medical institution means a ~~skilled~~ nursing facility, ~~intermediate care facility,~~ intermediate care facility for the mentally retarded, ~~nursing facility,~~ or inpatient hospital.

(2) The debt accruing under subsection (1) of this section arises during the life of the recipient but shall be held in abeyance until the death of the recipient. Any such debt to the department that exists when the recipient dies shall be recovered

only after the death of the recipient's spouse, if any, and only when the recipient is not survived by a child who either is under twenty-one years of age or is blind or totally and permanently disabled as defined by the Supplemental Security Income criteria.

(3) The debt shall include the total amount of medical assistance provided when the recipient was fifty-five years of age or older or during a period of institutionalization as described in subsection (1) of this section and shall not include interest.

(4) In any probate proceedings in which the department has filed a claim under this section, no additional evidence of foundation shall be required for the admission of the department's payment record supporting its claim if the payment record bears the seal of the department, is certified as a true copy, and bears the signature of an authorized representative of the department.

(5) The department may waive or compromise its claim, in whole or in part, if the department determines that enforcement of the claim would not be in the best interests of the state or would result in undue hardship.

~~(6) The department may adopt and promulgate rules and regulations to carry out this section.~~

Sec. 20. Section 68-1036.03, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1036.03~~ The ~~Department of Health and Human Services Finance and Support~~ department may garnish the wages, salary, or other employment income of a person for the costs of health services provided to a child who is eligible for medical assistance pursuant to the medical assistance program ~~established pursuant to~~

AM7216
LB 1248
MHF-4/10/2006

~~sections 68-1018 to 68-1025~~ if:

(1) The person is required by court or administrative order to provide health care coverage for the costs of such services; and

(2) The person has received payment from a third party for the costs of such services but has not used the payment to reimburse either the other parent or guardian or the provider of such services.

The amount garnished shall be limited to the amount necessary to reimburse the department for its expenditures for the costs of such services under the medical assistance program. Any claim for current or past-due child support shall take priority over a claim for the costs of health services.

Sec. 21. Section 68-1038, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1038~~ For purposes of sections ~~68-1038 to 68-1043~~ 21 to 25 of this act:

(1) Assets means property which is not exempt~~, under rules and regulations of the director,~~ from consideration in determining eligibility for medical assistance under rules and regulations adopted and promulgated under section 22 of this act;

(2) Community spouse monthly income allowance means the amount of income determined by the ~~department~~ Department of Health and Human Services in accordance with section 1924 of the federal Social Security Act, as amended, Public Law 100-360, 42 U.S.C. 1396r-5;

(3) Community spouse resource allowance means the amount

of assets determined in accordance with section 1924 of the federal Social Security Act, as amended, Public Law 100-360, 42 U.S.C. 1396r-5. For purposes of 42 U.S.C. 1396r-5(f)(2)(A)(i), the amount specified by the state shall be twelve thousand dollars;

~~(4) Department means the Department of Health and Human Services;~~

~~(5) Director means the Director of Health and Human Services;~~

~~(6)~~ (4) Home and community-based services means services furnished under home and community-based waivers as defined in Title XIX of the federal Social Security Act, as amended, 42 U.S.C. 1396;

~~(7) Medical assistance means assistance provided pursuant to the program established by section 68-1018;~~

~~(8)~~ (5) Qualified applicant means a person (a) who applies for medical assistance on or after July 9, 1988, (b) who is under care in a state-licensed hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, nursing facility, assisted-living facility, or center for the developmentally disabled, as such terms are defined in the Health Care Facility Licensure Act, or an adult family home certified by the ~~department~~ Department of Health and Human Services or is receiving home and community-based services, and (c) whose spouse is not under such care or receiving such services and is not applying for or receiving medical assistance;

~~(9)~~ (6) Qualified recipient means a person (a) who has applied for medical assistance before July 9, 1988, and is eligible

for such assistance, (b) who is under care in a facility certified to receive medical assistance funds ~~under sections 68-1018 to 68-1036~~ or is receiving home and community-based services, and (c) whose spouse is not under such care or receiving such services and is not applying for or receiving medical assistance; and

~~(10)~~ (7) Spouse means the spouse of a qualified applicant or qualified recipient.

Sec. 22. Section 68-1039, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1039~~ For purposes of determining medical assistance eligibility and the right to and obligation of medical support pursuant to ~~sections~~ section 68-716~~, 68-1020, and 68-1026~~ and sections 15 and 16 of this act, a spouse ~~shall be entitled to~~ may retain (1) assets equivalent to the community spouse resource allowance and (2) an amount of income equivalent to the community spouse monthly income allowance.

The ~~department~~ Department of Health and Human Services shall administer ~~the entitlements provided in~~ this section in accordance with section 1924 of the Social Security Act, as amended, Public Law 100-360, 42 U.S.C. 1396r-5, and shall adopt and promulgate rules and regulations as necessary to implement and enforce sections ~~68-1038 to 68-1043~~ 21 to 25 of this act.

Sec. 23. Section 68-1040, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1040~~ If a portion of the aggregate assets is designated in accordance with section ~~68-1042~~ 24 of this act:

(1) Only the assets not designated for the spouse shall

be considered in determining the eligibility of an applicant for medical assistance;

(2) In determining the eligibility of an applicant, ~~the director shall not take into account~~ the assets designated for the spouse ~~and~~ shall not ~~require~~ be taken into account and proof of adequate consideration for any assignment or transfer made as a result of the ~~entitlement to~~ designation of assets shall not be required;

(3) The assets designated for the spouse shall not be considered to be available to an applicant or recipient for future medical support and the spouse shall have no duty of future medical support of the applicant or recipient from such assets;

(4) ~~Neither the director nor the state may recover~~ Recovery may not be made from the assets designated for the spouse for any amount paid for future medical assistance provided to the applicant or recipient; and

(5) Neither the ~~director~~ Director of Health and Human Services nor the state shall be subrogated to or assigned any future right of the applicant or recipient to medical support from the assets designated for the spouse.

Sec. 24. Section 68-1042, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1042~~ A designation of assets pursuant to ~~the entitlement provided for in~~ section ~~68-1039~~ 22 of this act shall be evidenced by a written statement listing such assets and signed by the spouse. A copy of such statement shall be provided to the ~~director~~ Director of Health and Human Services at the time

of application and shall designate assets owned as of the date of application. Failure to complete any assignments or transfers necessary to place the designated assets in sole ownership of the spouse within a reasonable time after the statement is signed as provided in rules and regulations ~~of the director~~ adopted and promulgated under section 22 of this act may render the applicant or recipient ineligible for assistance in accordance with such rules and regulations.

Sec. 25. Section 68-1043, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1043~~ The Department of Health and Human Services shall furnish to each qualified applicant for and each qualified recipient of medical assistance a clear and simple written statement explaining the ~~entitlements provided in~~ provisions of section ~~68-1039~~ 22 of this act.

Sec. 26. Section 68-10,100, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,100~~ The Legislature finds that (1) the Department of Health and Human Services and the Department of Health and Human Services Finance and Support rely on health insurance and claims information from private insurers to ensure accuracy in processing state benefit program payments to providers and in verifying individual recipients' eligibility, (2) delay or refusal to provide such information causes unnecessary expenditures of state funds, (3) disclosure of such information to the Department of Health and Human Services and the Department of Health and Human Services Finance and Support is permitted pursuant to the federal Health

Insurance Portability and Accountability privacy rules under 45 C.F.R. part 164, and (4) for medical assistance program recipients who also have other insurance coverage, including coverage by licensed and self-funded insurers, the Department of Health and Human Services Finance and Support is required by 42 U.S.C. 1396a(a)(25) to assure that licensed and self-funded insurers coordinate benefits with the program.

Sec. 27. Section 68-10,101, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,101~~ For purposes of sections ~~68-10,100 to 68-10,107~~ 26 to 33 of this act:

(1) Coordinate benefits means:

(a) Provide to the Department of Health and Human Services or the Department of Health and Human Services Finance and Support information regarding the licensed insurer's or self-funded insurer's existing coverage for an individual who is eligible for a state benefit program; and

(b) Meet payment obligations;

(2) Coverage information means health information possessed by a licensed insurer or self-funded insurer that is limited to the following information about an individual:

(a) Eligibility for coverage under a health plan;

(b) Coverage of health care under the health plan; or

(c) Benefits and payments associated with the health plan;

(3) Health plan means any policy of insurance issued by a licensed insurer or any employee benefit plan offered by a

self-funded insurer that provides for payment to or on behalf of an individual as a result of an illness, disability, or injury or change in a health condition;

(4) Individual means a person covered by a state benefit program, including the medical assistance program, ~~established under sections 68-1018 to 68-1025,~~ or a person applying for such coverage;

(5) Licensed insurer means any insurer, except a self-funded insurer, including a fraternal benefit society, producer, or other person licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of the state; and

(6) Self-funded insurer means any employer or union who or which provides a self-funded employee benefit plan.

Sec. 28. Section 68-10,102, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,102~~ (1) Except as provided in subsection (2) of this section, at the request of the Department of Health and Human Services or the Department of Health and Human Services Finance and Support, a licensed insurer or a self-funded insurer shall provide coverage information to the requesting department without an individual's authorization for purposes of:

(a) Determining an individual's eligibility for state benefit programs, including the medical assistance program; ~~established under sections 68-1018 to 68-1025;~~ or

(b) Coordinating benefits with state benefit programs.

Such information shall be provided within thirty days

after the date of request unless good cause is shown. Requests for coverage information shall specify individual recipients for whom information is being requested.

(2)(a) Coverage information requested pursuant to subsection (1) of this section regarding a limited benefit policy shall be limited to whether a specified individual has coverage and, if so, a description of that coverage, and such information shall be used solely for the purposes of subdivision (1)(a) of this section.

(b) For purposes of this section, limited benefit policy means a policy of insurance issued by a licensed insurer that consists only of one or more, or any combination of the following:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Coverage for specified disease or illness; or

(iii) Hospital indemnity or other fixed indemnity insurance.

Sec. 29. Section 68-10,103, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,103~~ Any violation of section ~~68-10,102~~ 28 of this act by a licensed insurer shall be subject to the Unfair Insurance Claims Settlement Practices Act.

Sec. 30. Section 68-10,104, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,104~~ The Department of Health and Human Services Finance and Support may impose and collect a civil penalty on a self-funded insurer who violates the requirements of section

~~68-10,102~~ 28 of this act if the department finds that the self-funded insurer:

(1) Committed the violation flagrantly and in conscious disregard of the requirements; or

(2) Has committed violations with such frequency as to indicate a general business practice to engage in that type of conduct.

The civil penalty shall not be more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation by the self-funded insurer was committed flagrantly and in conscious disregard of section ~~68-10,102~~ 28 of this act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars.

Sec. 31. Section 68-10,105, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,105~~ The Department of Health and Human Services Finance and Support is authorized to recover all amounts paid or to be paid to state benefit programs as a result of failure to coordinate benefits by a licensed insurer or a self-funded insurer.

Sec. 32. Section 68-10,106, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,106~~ The Department of Health and Human Services Finance and Support shall establish a process by rule and regulation for resolving any violation by a self-funded insurer of section ~~68-10,102~~ 28 of this act and for assessing the financial

penalties contained in section ~~68-10,104~~ 30 of this act. Any appeal of an action by the department under such policies shall be in accordance with the Administrative Procedure Act.

Sec. 33. Section 68-10,107, Revised Statutes Supplement, 2005, is amended to read:

~~68-10,107~~ All money collected as a civil penalty under section ~~68-10,103~~ ~~or~~ ~~68-10,104~~ 29 or 30 of this act shall be remitted to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Sec. 34. Section 68-1073, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1073~~ Sections ~~68-1073~~ ~~to~~ ~~68-1086~~ 34 to 47 of this act shall be known and may be cited as the False Medicaid Claims Act.

Sec. 35. Section 68-1074, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1074~~ For purposes of the False Medicaid Claims Act:

(1) Attorney General means the Attorney General, the office of the Attorney General, or a designee of the Attorney General;

(2) Claim means any request or demand, whether under a contract or otherwise, for money or property that is made to a contractor, grantee, provider, or other recipient if the state provides any portion of the money or property that is requested or demanded or if the government will reimburse the contractor, grantee, or other recipient for any portion of the money or property that is requested or demanded, whether or not the state pays any portion of such request or demand;

~~(3) Department means the Department of Health and Human Services Finance and Support;~~

~~(4)~~ (3) Good or service includes (a) any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim for payment and (b) any entry in the cost report, books of account, or other documents supporting such good or service;

~~(5)~~ (4) Knowing or knowingly means that a person, with respect to information:

(a) Has actual knowledge of such information;

(b) Acts in deliberate ignorance of the truth or falsity of such information; or

(c) Acts in reckless disregard of the truth or falsity of such information;

~~(6) Medicaid program means the medical assistance program under sections 68-1018 to 68-1025;~~

~~(7)~~ (5) Person means any body politic or corporate, society, community, the public generally, individual, partnership, limited liability company, joint-stock company, or association; and

~~(8)~~ (6) Recipient means an individual who is eligible to receive goods or services for which payment may be made under the ~~medicaid~~ medical assistance program.

Sec. 36. Section 68-1075, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1075~~ (1) A person presents a false medicaid claim and is subject to civil liability if such person:

(a) Knowingly presents, or causes to be presented, to an

officer or employee of the state, a false or fraudulent claim for payment or approval;

(b) Knowingly makes or uses, or causes to be made or used, a false record or statement to obtain payment or approval by the state of a false or fraudulent claim;

(c) Conspires to defraud the state by obtaining payment or approval by the state of a false or fraudulent claim;

(d) Has possession, custody, or control of property or money used, or that will be used, by the state and, intending to defraud the state or willfully conceal the property, delivers, or causes to be delivered, less property than the amount for which such person receives a certificate or receipt;

(e) Buys, or receives as a pledge of an obligation or debt, public property from any officer or employee of the state knowing that such officer or employee may not lawfully sell or pledge such property; or

(f) Knowingly makes, uses, or causes to be made or used, a false record or statement with the intent to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state.

(2) A person who presents a false medicaid claim under subsection (1) of this section is subject to, in addition to any other remedies that may be prescribed by law, a civil penalty of not more than ten thousand dollars. In addition to any civil penalty, a person who presents a false medicaid claim under subsection (1) of this section may be subject to damages in the amount of three times the amount of the false claim submitted to

the state due to the act of such person.

(3) If the state is the prevailing party in an action under the False Medicaid Claims Act, the defendant, in addition to penalties and damages, shall pay the state's costs and attorney's fees for the civil action brought to recover penalties or damages under the act.

(4) Liability under this section is joint and several for any act committed by two or more persons.

Sec. 37. Section 68-1076, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1076~~ A person violates the False Medicaid Claims Act, and is subject to civil liability as provided in section ~~68-1075~~ 36 of this act, if such person is a beneficiary of an inadvertent submission of a false medicaid claim to the state, and subsequently discovers and, knowing the claim is false, fails to report the claim to the department within sixty days of such discovery. The beneficiary is not obliged to make such a report to the department if more than six years have passed since submission of the claim.

Sec. 38. Section 68-1077, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1077~~ A person violates the False Medicaid Claims Act, and a claim submitted with regard to a good or service is deemed to be false and subjects such person to civil liability as provided in section ~~68-1075~~ 36 of this act, if he or she, acting on behalf of a provider providing such good or service to a recipient under the ~~medicaid~~ medical assistance program, charges, solicits, accepts, or receives anything of value in addition to the amount legally

payable under the ~~medicaid~~ medical assistance program in connection with a provision of such good or service knowing that such charge, solicitation, acceptance, or receipt is not legally payable.

Sec. 39. Section 68-1078, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1078~~ (1) A person violates the False Medicaid Claims Act and is subject to civil liability as provided in section ~~68-1075~~ 36 of this act and damages as provided in subsection (2) of this section if he or she:

(a) Having submitted a claim or received payment for a good or service under the ~~medicaid~~ medical assistance program, knowingly fails to maintain such records as are necessary to disclose fully the nature of all goods or services for which a claim was submitted or payment was received, or such records as are necessary to disclose fully all income and expenditures upon which rates of payment were based, for a period of at least six years after the date on which payment was received; or

(b) Knowingly destroys such records within six years from the date payment was received.

(2) A person who knowingly fails to maintain records or who knowingly destroys records within six years from the date payment for a claim was received shall be subject to damages in the amount of three times the amount of the claim submitted for which records were knowingly not maintained or knowingly destroyed.

(3) If the state is the prevailing party in an action under this section, the defendant, in addition to penalties and damages, shall pay the state's costs and attorney's fees for the

civil action brought to recover penalties or damages under the act.

Sec. 40. Section 68-1079, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1079~~ (1) In determining the amount of any penalties or damages awarded under the False Medicaid Claims Act, the following shall be taken into account:

(a) The nature of claims and the circumstances under which they were presented;

(b) The degree of culpability and history of prior offenses of the person presenting the claims;

(c) Coordination of the total penalties and damages arising from the same claims, goods, or services, whether based on state or federal statute; and

(d) Such other matters as justice requires.

(2)(a) Any person who presents a false medicaid claim is subject to civil liability as provided in section ~~68-1075~~ 36 of this act, except when the court finds that:

(i) The person committing the violation of the False Medicaid Claims Act furnished officials of the state responsible for investigating violations of the act with all information known to such person about the violation within thirty days after the date on which the defendant first obtained the information;

(ii) Such person fully cooperated with any state investigation of such violation; and

(iii) At the time such person furnished the state with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under the act with

respect to such violation and the person did not have actual knowledge of the existence of an investigation into such violation.

(b) The court may assess not more than two times the amount of the false medicaid claims submitted because of the action of a person coming within the exception under subdivision (2)(a) of this section, and such person is also liable for the state's costs and attorney's fees for a civil action brought to recover any penalty or damages.

(3) Amounts recovered under the False Medicaid Claims Act shall be remitted to the State Treasurer for credit to the Department of Health and Human Services Cash Fund, except that ~~civil penalties shall be credited to the permanent school fund~~ the State Treasurer shall distribute civil penalties in accordance with Article VII, section 5, of the Constitution of Nebraska.

Sec. 41. Section 68-1080, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1080~~ (1) A civil action under the False Medicaid Claims Act shall be brought within six years after the date the claim is discovered or should have been discovered by exercise of reasonable diligence and, in any event, no more than ten years after the date on which the violation of the act was committed.

(2) In an action brought under the act, the state shall prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

Sec. 42. Section 68-1081, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1081~~ (1) In any case involving allegations of civil

violations or criminal offenses under the False Medicaid Claims Act, the Attorney General may take full charge of any investigation or advancement or prosecution of the case.

(2) The department shall cooperate with the state medicaid fraud control unit in conducting such investigations, civil actions, and criminal prosecutions and shall provide such information for such purposes as may be requested by the Attorney General.

Sec. 43. Section 68-1082, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1082~~ The Attorney General shall:

(1) Establish a state medicaid fraud control unit that meets the standards prescribed by 42 U.S.C. 1396b(q); and

(2) ~~apply~~ Apply to the Secretary of Health and Human Services for certification of the unit under 42 U.S.C. 1396b(q).

Sec. 44. Section 68-1083, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1083~~ The state medicaid fraud control unit shall employ such attorneys, auditors, investigators, and other personnel as authorized by law to carry out the duties of the unit in an effective and efficient manner. The purpose of the state medicaid fraud control unit is to conduct a statewide program for the investigation and prosecution of medicaid fraud and violations of all applicable state laws relating to the providing of medical assistance and the activities of providers. ~~of such assistance.~~ The state medicaid fraud control unit may review and act on complaints of abuse and neglect of patients at health care facilities that

receive payments under the ~~medicaid~~ medical assistance program and may provide for collection or referral for collection of overpayments made under the ~~medicaid~~ medical assistance program that are discovered by the unit.

Sec. 45. Section 68-1084, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1084~~ In carrying out the duties and responsibilities under the False Medicaid Claims Act, the Attorney General may:

(1) Enter upon the premises of any ~~health care~~ provider participating in the ~~medicaid~~ medical assistance program (a) to examine all accounts and records that are relevant in determining the existence of fraud in the ~~medicaid~~ medical assistance program, (b) to investigate alleged abuse or neglect of patients, or (c) to investigate alleged misappropriation of patients' private funds. The accounts or records of a nonmedicaid patient may not be reviewed by, or turned over to, the Attorney General without the patient's written consent or a court order;

(2) Subpoena witnesses or materials, including medical records relating to ~~medicaid~~ recipients, within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings;

(3) Request and receive the assistance of any prosecutor or law enforcement agency in the investigation and prosecution of any violation of this section; and

(4) Refer to the department for collection each instance of overpayment to a provider ~~of health care~~ under the ~~medicaid~~

medical assistance program which is discovered during the course of an investigation.

Sec. 46. Section 68-1085, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1085~~ (1) Notwithstanding any other provision of law, the Attorney General, upon reasonable request, shall have full access to all records held by a provider, or by any other person on his or her behalf, that are relevant to the determination of (a) the existence of civil violations or criminal offenses under the False Medicaid Claims Act or related offenses, (b) the existence of patient abuse, mistreatment, or neglect, or (c) the theft of patient funds.

(2) In examining such records, the Attorney General shall safeguard the privacy rights of recipients, avoiding unnecessary disclosure of personal information concerning named recipients. The Attorney General may transmit such information as he or she deems appropriate to the department and to other agencies concerned with the regulation of health care facilities or health professionals.

(3) No person holding such records may refuse to provide the Attorney General access to such records for the purposes described in the act on the basis that release would violate (a) a recipient's right of privacy, (b) a recipient's privilege against disclosure or use, or (c) any professional or other privilege or right.

Sec. 47. Section 68-1086, Revised Statutes Cumulative Supplement, 2004, is amended to read:

~~68-1086~~ Any person who, after being ordered by a court

to comply with a subpoena issued under the False Medicaid Claims Act, fails in whole or in part to testify or to produce evidence, documentary or otherwise, shall be in contempt of court as if the failure was committed in the presence of the court. The court may assess a fine of not less than one hundred dollars nor more than one thousand dollars for each day such person fails to comply. No person shall be found to be in contempt of court nor shall any fine be assessed if compliance with such subpoena violates such person's right against self-incrimination.

Sec. 48. (1) The Medicaid Reform Council is established. The council shall consist of ten persons appointed by the chairperson of the committee, in consultation with the committee, the Governor, and the director. The council shall include, but not be limited to, at least one representative from each of the following: Providers, recipients of medical assistance, advocates for such recipients, business representatives, insurers, and elected officials. The chairperson of the committee shall appoint the chairperson of the council. Members of the council may be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

(2) The council shall (a) oversee and support implementation of reforms to the medical assistance program, including, but not limited to, reforms such as those contained in the Medicaid Reform Plan, (b) conduct at least two public meetings annually and other meetings at the call of the chairperson of the council, in consultation with the director and the chairperson of the committee, and (c) provide comments and recommendations to the

department regarding the administration of the medical assistance program and any proposed changes to such program.

(3) The Medicaid Reform Council and this section terminate on June 30, 2010.

Sec. 49. (1) It is the intent of the Legislature that the department implement reforms to the medical assistance program such as those contained in the Medicaid Reform Plan, including (a) an incremental expansion of home and community-based services for aged persons and persons with disabilities consistent with such plan, (b) an increase in care coordination or disease management initiatives to better manage medical assistance expenditures on behalf of high-cost recipients with multiple or chronic medical conditions, and (c) other reforms as deemed necessary and appropriate by the department, in consultation with the committee and the Medicaid Reform Council.

(2)(a) The department shall develop recommendations relating to the provision of health care and related services for medicaid-eligible children under the state children's health insurance program as allowed under Title XIX and Title XXI of the federal Social Security Act. Such study and recommendations shall include, but not be limited to, the organization and administration of such program, the establishment of premiums, copayments, and deductibles under such program, and the establishment of limits on the amount, scope, and duration of services offered to recipients under such program.

(b) The department shall provide a draft report of such recommendations to the committee and the Medicaid Reform Council

no later than October 1, 2007. The council shall conduct a public meeting no later than October 15, 2007, to discuss and receive public comment regarding such report. The council shall provide any comments and recommendations regarding such report in writing to the director and the committee no later than November 1, 2007. The department shall provide a final report of such recommendations to the Governor, the committee, and the council no later than December 1, 2007.

(3)(a) The department shall develop recommendations for further modification or replacement of the defined benefit structure of the medical assistance program. Such recommendations shall be consistent with the public policy in section 5 of this act and shall consider the needs and resources of low-income Nebraska residents who are eligible or may become eligible for medical assistance, the experience and outcomes of other states that have developed and implemented such changes, and other relevant factors as determined by the department.

(b) The department shall provide a draft report of such recommendations to the committee and the Medicaid Reform Council no later than October 1, 2008. The council shall conduct a public meeting no later than October 15, 2008 to discuss and receive public comment regarding such report. The council shall provide any comments and recommendations regarding such report in writing to the director and the committee no later than November 1, 2008. The department shall provide a final report of such recommendations to the Governor, the committee, and the council no later than December 1, 2008.

Sec. 50. Section 25-21,188.02, Revised Statutes Cumulative Supplement, 2004, is amended to read:

25-21,188.02 (1) A person credentialed under the Uniform Licensing Law to practice as a physician, osteopathic physician, pharmacist, dentist, physician assistant, nurse, or physical therapist who, without the expectation or receipt of monetary or other compensation either directly or indirectly, provides professional services, of a kind which are eligible for reimbursement under the medical assistance program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act, as a volunteer in a free clinic or other facility operated by a not-for-profit organization as defined in section 25-21,190, by an agency of the state, or by any political subdivision shall be immune from civil liability for any act or omission which results in damage or injury unless such damage or injury was caused by the willful or wanton act or omission of such practitioner.

(2) The individual immunity granted by subsection (1) of this section shall not extend to any act or omission of such practitioner which results in damage or injury if:

(a) The free clinic or other facility is operated by a licensed hospital;

(b) The practitioner has been disciplined by the professional board having oversight over that practitioner in the previous five years at the time of the act or omission causing injury; or

(c) The damage or injury is caused by such practitioner (i) during the operation of any motor vehicle, airplane, or boat

or (ii) while impaired by alcohol or any controlled substance enumerated in section 28-405.

Sec. 51. Section 28-705, Reissue Revised Statutes of Nebraska, is amended to read:

28-705 (1) Any person who abandons and neglects or refuses to maintain or provide for his or her spouse or his or her child or dependent stepchild, whether such child is born in or out of wedlock, commits abandonment of spouse, child, or dependent stepchild.

(2) For the purposes of this section, child shall mean an individual under the age of sixteen years.

(3) When any person abandons and neglects to provide for his or her spouse or his or her child or dependent stepchild for three consecutive months or more, it shall be prima facie evidence of intent to violate the provisions of subsection (1) of this section.

(4) A designation of assets for or use of income by an individual in accordance with ~~the entitlements provided for in~~ section ~~68-1039~~ 22 of this act shall be considered just cause for failure to use such assets or income to provide medical support of such individual's spouse.

(5) Abandonment of spouse, child, or dependent stepchild is a Class I misdemeanor.

Sec. 52. Section 28-706, Reissue Revised Statutes of Nebraska, is amended to read:

28-706 (1) Any person who intentionally fails, refuses, or neglects to provide proper support which he or she knows or

reasonably should know he or she is legally obliged to provide to a spouse, minor child, minor stepchild, or other dependent commits criminal nonsupport.

(2) A parent or guardian who refuses to pay hospital costs, medical costs, or any other costs arising out of or in connection with an abortion procedure performed on a minor child or minor stepchild does not commit criminal nonsupport if:

(a) Such parent or guardian was not consulted prior to the abortion procedure; or

(b) After consultation, such parent or guardian refused to grant consent for such procedure, and the abortion procedure was not necessary to preserve the minor child or stepchild from an imminent peril that substantially endangered her life or health.

(3) Support includes, but is not limited to, food, clothing, medical care, and shelter.

(4) A designation of assets for or use of income by an individual in accordance with ~~the entitlements provided for in~~ section ~~68-1039~~ 22 of this act shall be considered just cause for failure to use such assets or income to provide medical support of such individual's spouse.

(5) This section does not exclude any applicable civil remedy.

(6) Except as provided in subsection (7) of this section, criminal nonsupport is a Class II misdemeanor.

(7) Criminal nonsupport is a Class IV felony if it is in violation of any order of any court.

Sec. 53. Section 30-2487, Revised Statutes Cumulative

Supplement, 2004, is amended to read:

30-2487 (a) If the applicable assets of the estate are insufficient to pay all claims in full, the personal representative shall make payment in the following order:

(1) Costs and expenses of administration;

(2) Reasonable funeral expenses;

(3) Debts and taxes with preference under federal law;

(4) Reasonable and necessary medical and hospital expenses of the last illness of the decedent, including compensation of persons attending the decedent and claims filed by the Department of Health and Human Services Finance and Support pursuant to section ~~68-1036.02~~ 19 of this act;

(5) Debts and taxes with preference under other laws of this state;

(6) All other claims.

(b) No preference shall be given in the payment of any claim over any other claim of the same class, and a claim due and payable shall not be entitled to a preference over claims not due.

Sec. 54. Section 43-512.12, Reissue Revised Statutes of Nebraska, is amended to read:

43-512.12 Child support orders in cases in which a party has applied for services under Title IV-D of the federal Social Security Act, as amended, shall be reviewed by the Department of Health and Human Services to determine whether to refer such orders to the county attorney or authorized attorney for filing of an application for modification. An order shall be reviewed by the department upon its own initiative or at the request of either

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LB 1248
MHF-4/10/2006

parent when such review is required by Title IV-D of the federal Social Security Act, as amended. After review the department shall refer an order to a county attorney or authorized attorney when the verifiable financial information available to the department indicates:

(1) The present child support obligation varies from the Supreme Court child support guidelines pursuant to section 42-364.16 by more than the percentage, amount, or other criteria established by Supreme Court rule, and the variation is due to financial circumstances which have lasted at least three months and can reasonably be expected to last for an additional six months; or

(2) Health insurance is available to the obligor as provided in subsection (2) of section 42-369 and the children are not covered by health insurance other than the medical assistance program under ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act.

An order shall not be reviewed by the department if it has not been three years since the present child support obligation was ordered. An order shall not be reviewed by the department more than once every three years unless the requesting party demonstrates a substantial change in circumstances, and an order may be reviewed after one year if the department's determination after the previous review was not to refer to the county attorney or authorized attorney for filing of an application for modification because financial circumstances had not lasted or were not expected to last for the time periods established by subdivision (1) of this section.

Sec. 55. Section 43-2508, Reissue Revised Statutes of Nebraska, is amended to read:

43-2508 (1) The Department of Health and Human Services shall be responsible for providing or contracting for services.

(2) Whenever possible, the medical assistance program prescribed in ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act shall be used for payment of services coordination.

(3) It is the intent of this section that the Department of Health and Human Services Finance and Support shall apply for and implement a Title XIX medicaid waiver as a way to assist in the provision of services coordination to eligible infants or toddlers with disabilities and their families.

Sec. 56. Section 44-3,144, Reissue Revised Statutes of Nebraska, is amended to read:

44-3,144 For purposes of sections 44-3,144 to 44-3,150:

(1) Authorized attorney has the same meaning as in section 43-512;

(2) Child means an individual to whom or on whose behalf a legal duty of support is owed by an obligor;

(3) Department means the Department of Health and Human Services;

(4) Employer means an individual, a firm, a partnership, a corporation, an association, a union, a political subdivision, a state agency, or any agent thereof who pays income to an obligor on a periodic basis and has or provides health care coverage to the obligor-employee;

(5) Health care coverage means a health benefit plan

or combination of plans, other than public medical assistance programs, that provide medical care or benefits;

(6) Insurer means an insurer as defined in section 44-103 offering a group health plan as defined in 29 U.S.C. 1167, as such section existed on January 1, 2002;

(7) Medical support means the provision of health care coverage, contribution to the cost of health care coverage, contribution to expenses associated with the birth of a child, other uninsured medical expenses of a child, or any combination thereof;

(8) Medical assistance program means the program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act;

(9) National medical support notice means a uniform administrative notice issued by the county attorney, authorized attorney, or department to enforce the medical support provisions of a support order;

(10) Obligee has the same meaning as in section 43-3341;

(11) Obligor has the same meaning as in section 43-3341;

(12) Plan administrator means the person or entity that administers health care coverage for an employer;

(13) Qualified medical child support order means an order that meets the requirements of 29 U.S.C. 1169, as such section existed on January 1, 2002; and

(14) Uninsured medical expenses means the reasonable and necessary health-related expenses that are not paid by health care coverage.

Sec. 57. Section 44-3,149, Reissue Revised Statutes of Nebraska, is amended to read:

44-3,149 An insurer shall, in any case in which a child has health care coverage through the insurer of the obligor:

(1) Provide such information to the obligor as may be necessary for the child to obtain benefits through such coverage;

(2) Permit the obligor or the provider, with the obligor's approval, to submit claims for covered services without the approval of the obligor; and

(3) Make payment on claims submitted in accordance with subdivision (2) of this section directly to such obligor, the provider, or the department pursuant to section ~~68-1026~~ 16 of this act.

Sec. 58. Section 44-526, Reissue Revised Statutes of Nebraska, is amended to read:

44-526 For purposes of the Standardized Health Claim Form Act:

(1) Ambulatory surgical facility shall mean a facility, not a part of a hospital, which provides surgical treatment to patients not requiring hospitalization and which is licensed as a health clinic as defined by section 71-416 but shall not include the offices of private physicians or dentists whether for individual or group practice;

(2) Health care shall mean any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease or injury or congenital or degenerative condition;

(3) Health care practitioner shall mean an individual

or group of individuals in the form of a partnership, limited liability company, or corporation licensed, certified, or otherwise authorized or permitted by law to administer health care in the course of professional practice and shall include the health care professions and occupations which are regulated in Chapter 71;

(4) Hospital shall mean a hospital as defined by section 71-419 except state hospitals administered by the Department of Health and Human Services;

(5) Institutional care providers shall mean all facilities licensed or otherwise authorized or permitted by law to administer health care in the ordinary course of business and shall include all health care facilities defined in the Health Care Facility Licensure Act;

(6) Issuer shall mean an insurance company, fraternal benefit society, health maintenance organization, third-party administrator, or other entity reimbursing the costs of health care expenses;

(7) Medicaid shall mean the medical assistance program pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act;

(8) Medicare shall mean Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 et seq., as amended; and

(9) Uniform claim form shall mean the claim forms and electronic transfer procedures developed pursuant to section 44-527.

Sec. 59. Section 44-1540, Revised Statutes Supplement, 2005, is amended to read:

44-1540 Any of the following acts or practices by an

insurer, if committed in violation of section 44-1539, shall be an unfair claims settlement practice:

(1) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of property and casualty claims (a) in which coverage and the amount of the loss are reasonably clear and (b) for loss of tangible personal property within real property which is insured by a policy subject to section 44-501.02 and which is wholly destroyed by fire, tornado, windstorm, lightning, or explosion;

(6) Compelling insureds or beneficiaries to institute litigation to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in litigation brought by them;

(7) Refusing to pay claims without conducting a reasonable investigation;

(8) Failing to affirm or deny coverage of a claim within

a reasonable time after having completed its investigation related to such claim;

(9) Attempting to settle a claim for less than the amount to which a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

(10) Attempting to settle claims on the basis of an application which was materially altered without notice to or knowledge or consent of the insured;

(11) Making a claims payment to an insured or beneficiary without indicating the coverage under which each payment is being made;

(12) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof-of-loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof-of-loss form;

(13) Failing, in the case of the denial of a claim or the offer of a compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such action;

(14) Failing to provide forms necessary to present claims with reasonable explanations regarding their use within fifteen working days of a request;

(15) Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or affiliated with the insurer are performed in a skillful manner. For purposes of this subdivision, a repairer is affiliated with the insurer

if there is a preexisting arrangement, understanding, agreement, or contract between the insurer and repairer for services in connection with claims on policies issued by the insurer;

(16) Requiring the insured or claimant to use a particular company or location for motor vehicle repair. Nothing in this subdivision shall prohibit an insurer from entering into discount agreements with companies and locations for motor vehicle repair or otherwise entering into any business arrangements or affiliations which reduce the cost of motor vehicle repair if the insured or claimant has the right to use a particular company or reasonably available location for motor vehicle repair. If the insured or claimant chooses to use a particular company or location other than the one providing the lowest estimate for like kind and quality motor vehicle repair, the insurer shall not be liable for any cost exceeding the lowest estimate. For purposes of this subdivision, motor vehicle repair shall include motor vehicle glass replacement and motor vehicle glass repair; and

(17) Failing to provide coverage information or coordinate benefits pursuant to section ~~68-10,102~~ 28 of this act.

Sec. 60. Section 44-32,180, Reissue Revised Statutes of Nebraska, is amended to read:

44-32,180 (1) Any health maintenance organization subject to the Health Maintenance Organization Act shall also be subject to (a) the premium taxation provisions of Chapter 77, article 9, to the extent that the direct writing premiums are not otherwise subject to taxation under such article and (b) the retaliatory taxation provisions of section 44-150.

(2) Except as provided in subsection (3) of this section, any capitation payment made in accordance with the ~~Managed Care Plan~~ Medical Assistance Act shall be excluded from computation of any tax obligation ~~due and payable on or after March 1, 1996,~~ imposed by subsection (1) of this section.

(3) Upon approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services of federal financial participation based upon the changes made by Laws 2002, LB 9, Ninety-seventh Legislature, Second Special Session, any capitation payment made in accordance with the ~~Managed Care Plan~~ Medical Assistance Act shall be included in the computation of any tax obligation imposed by subsection (1) of this section.

Sec. 61. Section 44-4221, Reissue Revised Statutes of Nebraska, is amended to read:

44-4221 (1) To be eligible to purchase health insurance coverage from the pool, an individual shall:

(a) Be a resident of the state for a period of at least six months and shall:

(i) Have received, within six months prior to application to the pool, a rejection in writing, for reasons of health, from an insurer;

(ii) Currently have, or have been offered within six months prior to application to the pool, health insurance coverage by an insurer which includes a restrictive rider which limits insurance coverage for a preexisting medical condition; or

(iii) Have been refused health insurance coverage

comparable to the pool, or have been offered such coverage at a rate exceeding the premium rate for pool coverage, within six months prior to application to the pool;

(b) Be a resident of the state for any length of time and be an individual:

(i) For whom, as of the date the individual seeks pool coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(ii) Who is not eligible for coverage under a group health plan, medicare, or medical assistance pursuant to the Medical Assistance Act or section 43-522, ~~or sections 68-1018 to 68-1025,~~ or any successor program, and who does not have any other health insurance coverage;

(iii) With respect to whom the most recent prior creditable coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(iv)(A) Who, if such individual was offered the option of continuation coverage under COBRA or under a similar program, both elected such continuation coverage and exhausted such continuation coverage, or (B) who had been offered the option of continuation coverage under COBRA or under a similar program at a premium rate higher than that available from the pool; or

(c) Be a resident of the state for any length of time and be a qualified trade adjustment assistance eligible individual.

(2) The board may adopt and promulgate a list of medical

or health conditions for which an individual would be eligible for pool coverage without applying for health insurance coverage pursuant to subdivision (1)(a) of this section. Individuals who can demonstrate the existence or history of any medical or health conditions on the list adopted and promulgated by the board shall be eligible to apply directly to the pool for health insurance coverage.

Sec. 62. Section 44-4222, Reissue Revised Statutes of Nebraska, is amended to read:

44-4222 (1) An individual shall not be eligible for initial or continued pool coverage if:

(a) He or she is eligible for medicare benefits by reason of age or medical assistance established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act;

(b) He or she is a resident or inmate of a correctional facility, except that this subdivision shall not apply if such individual is eligible for pool coverage under subdivision (1)(b) of section 44-4221;

(c) He or she has terminated pool coverage unless twelve months have elapsed since such termination, except that this subdivision shall not apply if such individual has received and become ineligible for medical assistance pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act during the immediately preceding twelve months, if such individual is eligible for pool coverage under subdivision (1)(b) of section 44-4221, or if such individual is eligible for waiver of any waiting period or preexisting condition exclusions pursuant to section 44-4228;

(d) The pool has paid out one million dollars in claims for the individual; or

(e) He or she is no longer a resident of Nebraska.

(2) Pool coverage shall terminate for any individual on the date the individual becomes ineligible under subsection (1) of this section.

Sec. 63. Section 44-4228, Reissue Revised Statutes of Nebraska, is amended to read:

44-4228 (1) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of pool coverage as to any condition (a) which had manifested itself during the six-month period immediately preceding the effective date of pool coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment or (b) for which medical advice, care, or treatment was recommended or received during the six-month period immediately preceding the effective date of pool coverage.

(2) Any individual whose health coverage is involuntarily terminated on or after January 1, 1992, and who is not eligible for a conversion policy or a continuation-of-coverage policy or contract available under state or federal law may apply for pool coverage but shall submit proof of eligibility pursuant to subdivision (1)(a) of section 44-4221. If such proof is supplied and if pool coverage is applied for under the Comprehensive Health Insurance Pool Act within sixty days after the involuntary termination and if premiums are paid to the pool for the entire coverage period, any waiting period or preexisting condition

exclusions provided for under the pool coverage shall be waived to the extent similar exclusions, if any, under the previous health coverage have been satisfied and the effective date of the pool coverage shall be the day following termination of the previous health coverage. The board may assess an additional premium for pool coverage provided pursuant to this subsection notwithstanding the premium limitations stated in section 44-4227. For purposes of this section, an individual whose health coverage is involuntarily terminated means an individual whose health insurance or health plan is terminated by reason of the withdrawal by the insurer from this state, bankruptcy or insolvency of the employer or employer trust fund, or cessation by the employer of providing any group health plan for all of its employees.

(3) Any individual whose health coverage under a continuation-of-coverage policy or contract available under state or federal law terminates or is involuntarily terminated on or after July 1, 1993, for any reasons other than nonpayment of premium may apply for pool coverage but shall submit proof of eligibility applied for within ninety days after the termination or involuntary termination. If premiums are paid to the pool for the entire coverage period, the effective date of the pool coverage shall be the day following termination of the previous coverage under the continuation-of-coverage policy or contract. Any waiting period or preexisting condition exclusions provided for under the pool shall be waived to the extent similar exclusions, if any, under any prior health coverage have been satisfied.

(4) Subsection (1) of this section shall not apply to

an individual who has received medical assistance pursuant to the Medical Assistance Act or section 43-522 ~~or sections 68-1018 to 68-1025~~ or an organ transplant recipient terminated from coverage under medicare during the six-month period immediately preceding the effective date of coverage.

(5) All waiting periods and preexisting conditions shall be waived for an individual eligible for pool coverage under subdivision (1)(b) of section 44-4221.

(6) The waiting period and preexisting condition exclusions are waived for a qualified trade adjustment assistance eligible individual under subdivision (1)(c) of section 44-4221 if the individual maintained creditable coverage for an aggregate period of three months as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a sixty-three-day break in coverage.

Sec. 64. Section 44-4726, Reissue Revised Statutes of Nebraska, is amended to read:

44-4726 (1) The same taxes provided for in section 44-32,180 shall be imposed upon each prepaid limited health service organization, and such organizations also shall be entitled to the same tax deductions, reductions, abatements, and credits that health maintenance organizations are entitled to receive.

(2) Except as provided in subsection (3) of this section, any capitation payment made in accordance with the ~~Managed Care Plan~~ Medical Assistance Act shall be excluded from computation of any tax obligation ~~due and payable on or after March 1, 1996,~~ imposed by subsection (1) of this section.

(3) Upon approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services of federal financial participation based upon the changes made by Laws 2002, LB 9, Ninety-seventh Legislature, Second Special Session, any capitation payment made in accordance with the ~~Managed Care Plan~~ Medical Assistance Act shall be included in the computation of any tax obligation imposed by subsection (1) of this section.

Sec. 65. Section 44-5305, Reissue Revised Statutes of Nebraska, is amended to read:

44-5305 (1) An uninsured access coverage policy or contract shall limit eligibility to individuals or families:

(a) Whose gross income does not exceed one hundred eighty-five percent of income standards prescribed by the federal Office of Management and Budget income poverty guidelines in effect on February 1, 1991, or as may be later amended; and

(b) Who are not eligible for medicare or any other medical assistance program, including, but not limited to, the program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act.

(2) Every uninsured access coverage policy or contract shall specify the time period, not exceeding six months, for which any applicant is required to demonstrate eligibility based upon the income standards of such policy or contract, and every such policy or contract shall specify what constitutes sufficient verification of income at the time of application and annual renewals.

(3) If an individual's or a family's income exceeds

the income eligibility standards of the uninsured access coverage policy or contract and such individual or family is thereby no longer eligible for continued coverage, the uninsured access coverage policy or contract shall allow a transfer to a designated type of individual policy or contract without evidence of insurability and without interruption in coverage subject to payment of premiums. Each uninsured access coverage policy or contract shall specify the type of individual policy or contract to which an insured person may transfer.

Sec. 66. Section 44-8002, Revised Statutes Supplement, 2005, is amended to read:

44-8002 For purposes of the Health Care Prompt Payment Act:

(1) Claim form means an insurer's standard printed or electronic transaction form that complies with the standards issued by the Secretary of the United States Department of Health and Human Services or, if an insurer does not have a standard printed or electronic transaction form, any form which complies with such standards;

(2) Clean claim means a claim for payment of health care services that is submitted by a Nebraska health care provider to an insurer on a claim form with all required fields completed with information to adjudicate the claim in accordance with any published filing requirements of the insurer;

(3) Director means the Director of Insurance;

(4) Insurer means an entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of

health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, a participant in an insurance arrangement as defined in section 44-4105, or any other entity providing a plan of health insurance, health benefits, or health care services. Insurer does not include the medical assistance program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act, a property and liability insurer, a motor vehicle insurer, a workers' compensation insurer, a risk management pool, or a self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(5) Prompt payment act compliance statement means a certification made in good faith by an insurer that, during the twenty-four-month period ending on the preceding June 30, it paid, denied, or settled more than ninety percent of its clean claims within the time periods set forth in subsections (1) and (2) of section 44-8004;

(6) Repricer means an entity that receives claims from health care providers and submits them to insurers after adjudicating or repricing such claims; and

(7) Unfair payment pattern means any of the following patterns of conduct:

(a) Engaging in a demonstrable and unjust pattern of reviewing or processing complete and accurate claims that results in payment delays;

(b) Engaging in a demonstrable and unjust pattern of

reducing the amount of payment or denying complete and accurate claims;

(c) Repeated failure to pay the uncontested portions of a claim within the time periods specified in section 44-8004; or

(d) Failing on a repeated basis to pay the interest when due on claims pursuant to section 44-8005.

Sec. 67. Section 68-104, Reissue Revised Statutes of Nebraska, is amended to read:

68-104 The Department of Health and Human Services shall be the overseer of the poor and shall be vested with the entire and exclusive superintendence of the poor in this state, except that~~,~~ ~~subject to the limitations of section 68-1022,~~ the county board of each county shall furnish such medical service as may be required for the poor of the county who are not eligible for other medical assistance programs and general assistance for the poor of the county. Any person who is or becomes ineligible for other medical assistance programs due to his or her own actions or inactions shall also be ineligible for medical services from the county.

The county board of each county shall administer the medical assistance provided pursuant to this section. A county board may enter into an agreement with the Department of Health and Human Services which allows the department to aid in the administration of such medical assistance program. In providing medical and hospital care for the poor, the county board shall make use of any existing facilities, including tax-supported hospitals and charitable clinics so far as the same may be available, and shall use the financial eligibility criteria established for the

AM7216
LB 1248
MHF-4/10/2006

standard of need developed by the county pursuant to section 68-126.

Sec. 68. Section 68-150, Reissue Revised Statutes of Nebraska, is amended to read:

68-150 An application for county general assistance or for county health services shall give a right of subrogation to the county furnishing such aid. Subject to sections ~~68-1038 to 68-1043~~ 21 to 25 of this act, subrogation shall include every claim or right which the applicant may have against a third party when such right or claim involves money for medical care. The third party shall be liable to make payments directly to the county as soon as he or she is notified in writing of the valid claim for subrogation under this section.

Sec. 69. Section 68-716, Reissue Revised Statutes of Nebraska, is amended to read:

68-716 An application for medical assistance ~~benefits~~ shall give a right of subrogation to the Department of Health and Human Services Finance and Support or its assigns. Subject to sections ~~68-1038 to 68-1043~~ 21 to 25 of this act, subrogation shall include every claim or right which the applicant may have against a third party when such right or claim involves money for medical care. The third party shall be liable to make payments directly to the department or its assigns as soon as he or she is notified in writing of the valid claim for subrogation under this section.

Sec. 70. Section 68-1070, Reissue Revised Statutes of Nebraska, is amended to read:

~~68-1070~~ (1) If the following non-United-States citizens

meet the income and other requirements for participation in the medical assistance program established ~~under sections 68-1018 to 68-1026~~ pursuant to the Medical Assistance Act, in the program for financial assistance pursuant to section 43-512, in the food stamp program administered by the State of Nebraska pursuant to the federal Food Stamp Act, or in the program for assistance to the aged, blind, and disabled, such persons shall be eligible for such program or benefits:

(a) Non-United-States citizens lawfully admitted, regardless of the date entry was granted, into the United States for permanent residence;

(b) Refugees admitted under section 207 of the federal Immigration and Naturalization Act, non-United-States citizens granted asylum under section 208 of such federal act, and non-United-States citizens whose deportation is withheld under section 243(h) of such federal act, regardless of the date of entry into the United States; and

(c) Individuals for whom coverage is mandated under federal law.

(2) Individuals eligible for food stamp assistance under this section shall receive any food stamp coupons or electronic benefits or a state voucher which can be used only for food products authorized under the federal Food Stamp Act, in the amount of the food stamp benefit for which this individual was otherwise eligible but for the citizenship provisions of Public Law 104-193, 110 Stat. 2105 (1996).

(3) The income and resources of any individual who

assists a non-United-States citizen to enter the United States by signing an affidavit of support shall be deemed available in determining the non-United-States citizen's eligibility for assistance until the non-United-States citizen becomes a United States citizen.

Sec. 71. Section 68-1509, Reissue Revised Statutes of Nebraska, is amended to read:

68-1509 The department, in considering the needs and eligibility criteria of families and disabled persons, shall consider various factors, including, but not limited to:

(1) Total family income, except that the amount ~~to~~ which the spouse ~~is entitled~~ may designate as provided in section ~~68-1039~~ 22 of this act shall be excluded in determining total family income per month;

(2) The cost of providing supplemental services to the family or the disabled person;

(3) The need for each program or service received by the family or the disabled person;

(4) The eligibility of the family or the disabled person for other support programs;

(5) The costs of providing for the family or the disabled person in an independent living situation, notwithstanding the special circumstances of providing for a disabled person;

(6) The number of persons in the family; and

(7) The availability of insurance to cover the cost of needed programs and services.

If assets have been designated for an individual in

accordance with ~~the entitlement provided for in~~ section ~~68-1039~~ 22 of this act, such assets shall not be considered in determining the eligibility for support of the individual's disabled spouse.

Sec. 72. Section 68-1802, Revised Statutes Cumulative Supplement, 2004, is amended to read:

68-1802 For purposes of the ICF/MR Reimbursement Protection Act:

(1) Department means the Department of Health and Human Services Finance and Support;

(2) Intermediate care facility for the mentally retarded has the definition found in section 71-421;

(3) ~~Medicaid~~ Medical assistance program means the ~~medical assistance~~ program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act; and

(4) Net revenue means the revenue paid to an intermediate care facility for the mentally retarded for resident care, room, board, and services less contractual adjustments and does not include revenue from sources other than operations, including, but not limited to, interest and guest meals.

Sec. 73. Section 68-1803, Revised Statutes Cumulative Supplement, 2004, is amended to read:

68-1803 (1) Each intermediate care facility for the mentally retarded shall pay a tax equal to six percent of its net revenue for the most recent State of Nebraska fiscal year.

(2) Taxes collected under this section shall be remitted to the State Treasurer for credit to the ICF/MR Reimbursement Protection Fund.

(3) Taxes collected pursuant to this section shall be reported on a separate line on the cost report of the intermediate care facility for the mentally retarded, regardless of how such costs are reported on any other cost report or income statement. The department shall recognize such tax as an allowable cost within the state plan for reimbursement of intermediate care facilities for the mentally retarded which participate in the ~~medicaid~~ medical assistance program. The tax shall be a direct pass-through and shall not be subject to cost limitations.

Sec. 74. Section 71-804, Revised Statutes Cumulative Supplement, 2004, is amended to read:

71-804 For purposes of the Nebraska Behavioral Health Services Act:

(1) Administrator means the administrator of the division;

(2) Behavioral health disorder means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder;

(3) Behavioral health region means a behavioral health region established in section 71-807;

(4) Behavioral health services means services, including, but not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with such disorders;

(5) Community-based behavioral health services or

community-based services means behavioral health services that are not provided at a regional center;

(6) Department means the Department of Health and Human Services;

(7) Director means the Director of Health and Human Services;

(8) Division means the Division of Behavioral Health Services of the department;

(9) Medical assistance program means the program established pursuant to the Medical Assistance Act;

~~(9)~~ (10) Nebraska Health and Human Services System means the Department of Health and Human Services, the Department of Health and Human Services Regulation and Licensure, and the Department of Health and Human Services Finance and Support;

~~(10)~~ (11) Policy Cabinet means the Policy Cabinet of the Nebraska Health and Human Services System established in section 81-3009;

~~(11)~~ (12) Public behavioral health system means the statewide array of behavioral health services for children and adults provided by the public sector or private sector and supported in whole or in part with funding received and administered by the Nebraska Health and Human Services System, including behavioral health services provided under the medical assistance program; ~~established in section 68-1018;~~

~~(12)~~ (13) Regional center means one of the state hospitals for the mentally ill designated in section 83-305; and

~~(13)~~ (14) Regional center behavioral health services or regional center services means behavioral health services provided at a regional center.

Sec. 75. Section 71-806, Revised Statutes Cumulative Supplement, 2004, is amended to read:

71-806 (1) The division shall act as the chief behavioral health authority for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system, including, but not limited to: (a) Administration and management of the division, regional centers, and any other facilities and programs operated by the division; (b) integration and coordination of the public behavioral health system; (c) comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; (d) coordination and oversight of regional behavioral health authorities, including approval of regional budgets and audits of regional behavioral health authorities; (e) development and management of data and information systems; (f) prioritization and approval of all expenditures of funds received and administered by the division, including the establishment of rates to be paid and reimbursement methodologies for behavioral health services and fees to be paid by consumers of such services; (g) cooperation with the Department of Health and Human Services Regulation and Licensure in the licensure and regulation of behavioral health professionals, programs, and facilities; (h) cooperation with the Department of Health and Human Services Finance and Support in the provision of behavioral

health services under the medical assistance program; ~~established in section 68-1018;~~ (i) audits of behavioral health programs and services; and (j) promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services.

(2) The department shall adopt and promulgate rules and regulations to carry out the Nebraska Behavioral Health Services Act.

Sec. 76. Section 71-820, Revised Statutes Cumulative Supplement, 2004, is amended to read:

71-820 The behavioral health implementation plan required under section 71-819 shall be consistent with the Nebraska Behavioral Health Services Act and shall include, but not be limited to, a detailed description of all completed, current, and proposed activities by the division to:

(1) Select and appoint an administrator, chief clinical officer, program administrator for consumer affairs, and other staff within the division;

(2) Implement necessary and appropriate administrative and other changes within the Nebraska Health and Human Services System to carry out the Nebraska Behavioral Health Services Act;

(3) Describe and define the role and function of the office of consumer affairs within the division;

(4) Describe and define the relationship between the division and regional behavioral health authorities, including, but not limited to, the nature and scope of the coordination and

oversight of such authorities by the division;

(5) Encourage and facilitate the statewide development and provision of an appropriate array of community-based behavioral health services and continuum of care for both children and adults and the integration and coordination of such services with primary health care services;

(6)(a) Identify persons currently receiving regional center behavioral health services for whom community-based behavioral health services would be appropriate, (b) provide for the development and funding of appropriate community-based behavioral health services for such persons in each behavioral health region, (c) transition such persons from regional centers to appropriate community-based behavioral health services, (d) reduce new admissions and readmissions to regional centers, and (e) establish criteria, procedures, and timelines for the closure of the Norfolk Regional Center and the Hastings Regional Center and policies and procedures for the recruitment, retention, training, and support of regional center employees affected by such closures;

(7) Integrate all behavioral health funding within the Nebraska Health and Human Services System and allocate such funding to support the consumer and his or her plan of treatment;

(8) Establish (a) priorities for behavioral health services and funding, (b) rates and reimbursement methodologies for providers of behavioral health services and draft negotiated rulemaking policies and procedures for the development and implementation of such methodologies, and (c) fees to be paid by consumers of behavioral health services, which fees shall not

exceed the actual costs of providing such services;

(9) Access additional public and private funding for the provision of behavioral health services in each behavioral health region, including additional federal funding through the medical assistance program, ~~established in section 68-1018,~~ and establish programs and procedures for the provision of grants, loans, and other assistance for the provision of such services;

(10) Encourage and facilitate activities of the State Behavioral Health Council and the advisory committees making up such council; and

(11) Promote activities in research and education to improve the quality of behavioral health services, the recruitment and retention of behavioral health professionals, and the availability of behavioral health services.

Sec. 77. Section 71-2426, Revised Statutes Supplement, 2005, is amended to read:

71-2426 (1) A cancer drug shall only be accepted or dispensed under the program if such drug is in its original, unopened, sealed, and tamper-evident unit dose packaging, except that a cancer drug packaged in single unit doses may be accepted and dispensed if the outside packaging is opened but the single-unit-dose packaging is unopened.

(2) A cancer drug shall not be accepted or dispensed under the program if (a) such drug bears an expiration date that is earlier than six months after the date the drug was donated or (b) such drug is adulterated or misbranded as described in section 71-2401 or 71-2402.

(3) Subject to limitations provided in this section, unused cancer drugs dispensed under the medical assistance program established ~~in section 68-1018~~ pursuant to the Medical Assistance Act may be accepted and dispensed under the program.

Sec. 78. Section 71-6017.01, Reissue Revised Statutes of Nebraska, is amended to read:

71-6017.01 Medicaid ~~shall mean~~ means the medical assistance program ~~under sections 68-1018 to 68-1025~~ established pursuant to the Medical Assistance Act.

Sec. 79. Section 71-7607, Revised Statutes Cumulative Supplement, 2004, is amended to read:

71-7607 (1) The Nebraska Medicaid Intergovernmental Trust Fund is created. The fund shall include revenue received from governmental nursing facilities receiving payments for nursing facility services under the medical assistance program established pursuant to ~~section 68-1018~~ the Medical Assistance Act. The Department of Health and Human Services Finance and Support shall remit such revenue to the State Treasurer for credit to the fund. The department shall adopt and promulgate rules and regulations to establish procedures for participation by governmental nursing facilities and for the receipt of such revenue under this section. Money from the Nebraska Medicaid Intergovernmental Trust Fund shall be transferred to the Nebraska Health Care Cash Fund as provided in section 71-7611.

(2) The department may use revenue in the Nebraska Medicaid Intergovernmental Trust Fund to offset any unanticipated reductions in medicaid funds received under this section.

(3) For FY2003-04 and FY2004-05, transfers may be made from the fund to the Department of Health and Human Services Cash Fund, the Behavioral Health Services Fund, and the Attorney General Child Protection Cash Fund at the direction of the Legislature to fund child welfare and protection activities and emergency protective services. The Department of Administrative Services shall administratively create the Attorney General Child Protection Cash Fund to be administered by the office of the Attorney General for the purpose of receiving fund transfers to assist with the prosecution of crimes against children.

(4) The State Treasurer shall transfer two million two hundred twenty thousand dollars from the Nebraska Medicaid Intergovernmental Trust Fund to the Department of Health and Human Services Cash Fund on or before May 1, 2004. The State Treasurer shall transfer five million four hundred twenty thousand dollars from the Nebraska Medicaid Intergovernmental Trust Fund to the Department of Health and Human Services Cash Fund on or before July 15, 2004. The State Treasurer shall transfer eighty thousand dollars from the Nebraska Medicaid Intergovernmental Trust Fund to the Attorney General Child Protection Cash Fund on or before May 1, 2004. The State Treasurer shall transfer eighty thousand dollars from the Nebraska Medicaid Intergovernmental Trust Fund to the Attorney General Child Protection Cash Fund on or before July 15, 2004.

(5) Any money in the Nebraska Medicaid Intergovernmental Trust Fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act

and the Nebraska State Funds Investment Act.

Sec. 80. Section 71-7610, Reissue Revised Statutes of Nebraska, is amended to read:

71-7610 The Children's Health Insurance Cash Fund is created. The fund shall be used for the state's matching share for the children's health insurance program under Title XXI of the federal Social Security Act and for expenses incurred in the administration of such program. If the state's matching share for program and administrative expenses ~~are~~ is fully funded in any given fiscal year, any additional money in the fund may be used for the state's matching share for the medical assistance program ~~under sections 68-1018 to 68-1025~~ established pursuant to the Medical Assistance Act and for expenses incurred in the administration of the program. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

Sec. 81. Section 71-8405, Reissue Revised Statutes of Nebraska, is amended to read:

71-8405 (1) A provider shall not charge a fee for medical records requested by a patient for use in supporting an application for disability or other benefits or assistance or an appeal relating to the denial of such benefits or assistance under:

(a) Sections 43-501 to 43-536 regarding assistance for certain children;

(b) ~~Sections 68-1018 to 68-1025~~ The Medical Assistance Act relating to the medical assistance program;

(c) Title II of the federal Social Security Act, as amended, 42 U.S.C. 401 et seq.;

(d) Title XVI of the federal Social Security Act, as amended, 42 U.S.C. 1382 et seq.; or

(e) Title XVIII of the federal Social Security Act, as amended, 42 U.S.C. 1395 et seq.

(2) Unless otherwise provided by law, a provider may charge a fee as provided in section 71-8404 for the medical records of a patient requested by a state or federal agency in relation to the patient's application for benefits or assistance or an appeal relating to denial of such benefits or assistance under subsection (1) of this section.

(3) A request for medical records under this section shall include a statement or document from the department or agency that administers the issuance of the assistance or benefits which confirms the application or appeal.

Sec. 82. Section 71-8506, Reissue Revised Statutes of Nebraska, is amended to read:

71-8506 (1) On or after July 1, 2000, in-person contact between a health care practitioner and a patient shall not be required under the medical assistance program established ~~in sections 68-1018 to 68-1025~~ pursuant to the Medical Assistance Act and Title XXI of the federal Social Security Act, as amended, for health care services delivered through telehealth that are otherwise eligible for reimbursement under such program and federal act. Such services shall be subject to reimbursement policies developed pursuant to such program and federal act. This

section also applies to managed care plans which contract with the department pursuant to the ~~Managed Care Plan~~ Medical Assistance Act only to the extent that:

(a) Health care services delivered through telehealth are covered by and reimbursed under the medicaid fee-for-service program; and

(b) Managed care contracts with managed care plans are amended to add coverage of health care services delivered through telehealth and any appropriate capitation rate adjustments are incorporated.

(2) The reimbursement rate for a telehealth consultation shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person consultation.

(3) The department shall establish rates for transmission cost reimbursement for telehealth consultations, considering, to the extent applicable, reductions in travel costs by health care practitioners and patients to deliver or to access health care services and such other factors as the department deems relevant.

Sec. 83. Section 77-908, Reissue Revised Statutes of Nebraska, is amended to read:

77-908 Every insurance company organized under the stock, mutual, assessment, or reciprocal plan, except fraternal benefit societies, which is transacting business in this state shall, on or before March 1 of each year, pay a tax to the director of one percent of the gross amount of direct writing premiums received by it during the preceding calendar year for business done in this state, except that (1) for group sickness and accident insurance

the rate of such tax shall be five-tenths of one percent, (2) for property and casualty insurance, excluding individual sickness and accident insurance, the rate of such tax shall be one percent, and (3) for capitation payments made in accordance with the ~~Managed Care Plan~~ Medical Assistance Act, the rate of tax shall be five percent. The taxable premiums shall include premiums paid on the lives of persons residing in this state and premiums paid for risks located in this state whether the insurance was written in this state or not, including that portion of a group premium paid which represents the premium for insurance on Nebraska residents or risks located in Nebraska included within the group when the number of lives in the group exceeds five hundred. The tax shall also apply to premiums received by domestic companies for insurance written on individuals residing outside this state or risks located outside this state if no comparable tax is paid by the direct writing domestic company to any other appropriate taxing authority. Companies whose scheme of operation contemplates the return of a portion of premiums to policyholders, without such policyholders being claimants under the terms of their policies, may deduct such return premiums or dividends from their gross premiums for the purpose of tax calculations. Any such insurance company shall receive a credit on the tax imposed as provided in the Community Development Assistance Act and section 77-27,222.

Sec. 84. Section 77-912, Reissue Revised Statutes of Nebraska, is amended to read:

77-912 The Director of Insurance shall transmit fifty percent of the taxes paid in conformity with Chapter 44, article 1,

and Chapter 77, article 9, to the State Treasurer, forty percent of such taxes paid to the General Fund, and ten percent of such taxes paid to the Mutual Finance Assistance Fund promptly upon completion of his or her audit and examination and in no event later than May 1 of each year, except that:

(1) All fire insurance taxes paid pursuant to sections 44-150 and 81-523 shall be remitted to the State Treasurer for credit to the General Fund;

(2) All workers' compensation insurance taxes paid pursuant to section 44-150 shall be remitted to the State Treasurer for credit to the Compensation Court Cash Fund;

(3) Commencing with the premium and related retaliatory taxes for the taxable year ending December 31, 2001, and for each taxable year thereafter, all premium and related retaliatory taxes imposed by section 44-150 or 77-908 paid by insurers writing health insurance in this state shall be remitted to the Comprehensive Health Insurance Pool Distributive Fund; and

(4) All taxes paid pursuant to section 77-908 for capitation payments made in accordance with the ~~Managed Care Plan~~ Medical Assistance Act shall be remitted to the Department of Health and Human Services Finance and Support Cash Fund.

Sec. 85. Section 77-2704.09, Revised Statutes Supplement, 2005, is amended to read:

77-2704.09 (1) Sales and use taxes shall not be imposed on the gross receipts from the sale, lease, or rental of and the storage, use, or other consumption in this state of insulin and the following when sold for a patient's use under

a prescription and which are of the type eligible for coverage under the medical assistance program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act: Drugs, not including over-the-counter drugs; durable medical equipment; home medical supplies; prosthetic devices; oxygen; oxygen equipment; and mobility enhancing equipment.

(2) For purposes of this section:

(a) Drug means a compound, substance, preparation, and component of a compound, substance, or preparation, other than food and food ingredients, dietary supplements, or alcoholic beverages:

(i) Recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, and any supplement to any of them;

(ii) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; or

(iii) Intended to affect the structure or any function of the body;

(b) Durable medical equipment means equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, is appropriate for use in the home, and is not worn in or on the body. Durable medical equipment includes repair and replacement parts for such equipment;

(c) Home medical supplies means supplies primarily and customarily used to serve a medical purpose which are appropriate for use in the home and are generally not useful to a person in the

absence of illness or injury;

(d) Mobility enhancing equipment means equipment which is primarily and customarily used to provide or increase the ability to move from one place to another, which is not generally used by persons with normal mobility, and which is appropriate for use either in a home or a motor vehicle. Mobility enhancing equipment includes repair and replacement parts for such equipment. Mobility enhancing equipment does not include any motor vehicle or equipment on a motor vehicle normally provided by a motor vehicle manufacturer;

(e) Over-the-counter drug means a drug that contains a label that identifies the product as a drug as required by 21 C.F.R. 201.66, as such regulation existed on January 1, 2003. The over-the-counter drug label includes a drug facts panel or a statement of the active ingredients with a list of those ingredients contained in the compound, substance, or preparation;

(f) Oxygen equipment means oxygen cylinders, cylinder transport devices including sheaths and carts, cylinder studs and support devices, regulators, flowmeters, tank wrenches, oxygen concentrators, liquid oxygen base dispensers, liquid oxygen portable dispensers, oxygen tubing, nasal cannulas, face masks, oxygen humidifiers, and oxygen fittings and accessories;

(g) Prescription means an order, formula, or recipe issued in any form of oral, written, electronic, or other means of transmission by a duly licensed practitioner authorized under (i) the Advanced Practice Registered Nurse Act prior to July 1, 2007, and the Certified Registered Nurse Anesthetist Act, the Nebraska

Certified Nurse Midwifery Practice Act, or the Nurse Practitioner Act on and after July 1, 2007, (ii) Chapter 71, article 1, or (iii) sections 71-4701 to 71-4719; and

(h) Prosthetic devices means a replacement, corrective, or supportive device worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body, and includes any supplies used with such device and repair and replacement parts.

Sec. 86. Section 77-27,163.01, Reissue Revised Statutes of Nebraska, is amended to read:

77-27,163.01 The Department of Health and Human Services shall use the procedures in this section and sections 77-27,160 to 77-27,173 to set off against a debtor's income tax refund the costs of health services provided to a child of the debtor if:

(1) The debtor is required by court or administrative order to provide coverage for the costs of such services; and

(2) The debtor has received payment from a third party for the costs of such services but has not used the payment to reimburse either the other parent or guardian or the provider of such services.

The amount of the setoff shall be limited to the amount necessary to reimburse the department for its expenditures for the costs of such services under the medical assistance program established pursuant to ~~sections 68-1018 to 68-1025~~ the Medical Assistance Act. Any claim for current or past-due child support shall take priority over a claim for setoff for the costs of health

services.

Sec. 87. Section 79-215, Reissue Revised Statutes of Nebraska, is amended to read:

79-215 (1) Except as otherwise provided in this section, a student is a resident of the school district where he or she resides or any school district where at least one of his or her parents reside and shall be admitted to any such school district upon request without charge.

(2) A school board shall admit any homeless student that requests admission without charge.

(3) A school board may allow a student whose residency in the district ceases during a school year to continue attending school in such district for the remainder of that school year.

(4) A school board may admit nonresident students to the school district pursuant to a contract with the district where the student is a resident and shall collect tuition pursuant to the contract.

(5) A school board may admit nonresident students to the school district pursuant to the enrollment option program as authorized by sections 79-232 to 79-246, and such admission shall be without charge.

(6) A school board may admit a student who is a resident of another state to the school district and collect tuition in advance at a rate determined by the school board.

(7) When a student as a ward of the state or as a ward of any court (a) has been placed in a school district other than the district in which he or she resided at the time he or she

AM7216
LB 1248
MHF-4/10/2006

became a ward and such ward does not reside in a foster family home licensed or approved by the Department of Health and Human Services or a foster home maintained or used pursuant to section 83-108.04 or (b) has been placed in any institution which maintains a special education program which has been approved by the State Department of Education and such institution is not owned or operated by the district in which he or she resided at the time he or she became a ward, the cost of his or her education and the required transportation costs associated with the student's education shall be paid by the state, but not in advance, to the receiving school district or approved institution under rules and regulations prescribed by the Department of Health and Human Services and the student shall remain a resident of the district in which he or she resided at the time he or she became a ward. Any student who is a ward of the state or a ward of any court who resides in a foster family home licensed or approved by the Department of Health and Human Services or a foster home maintained or used pursuant to section 83-108.04 shall be deemed a resident of the district in which the foster family home or foster home is located.

(8) When a student is not a ward of the state or a ward of any court and is residing in a residential setting located in Nebraska for reasons other than to receive an education and the residential setting is operated by a service provider which is certified or licensed by the Department of Health and Human Services or is enrolled in the medical assistance program established ~~under sections 68-1018 to 68-1025~~ pursuant to the Medical Assistance Act and Title XIX or XXI of the federal

Social Security Act, as amended, the student shall remain a resident of the district in which he or she resided immediately prior to residing in such residential setting. Upon request by a parent or legal guardian, the resident school district shall contract with the district in which such residential setting is located for the provision of all educational services, including all special education services. If the parent or legal guardian has requested that the resident school district contract with the district in which such residential setting is located, the district in which such residential setting is located shall contract with the resident district and provide all educational services, including all special education services, to the student. If the two districts cannot agree on the amount of the contract, the State Department of Education shall determine the amount to be paid by the resident district to the district in which such residential setting is located based on the needs of the student, approved special education rates, the department's general experience with special education budgets, and the cost per student in the district in which such residential setting is located. Once the contract has been entered into, all legal responsibility for special education and related services shall be transferred to the school district in which the residential setting is located. The resident district for a student who is not a ward of the state or a ward of any court does not change when the student moves from one residential setting to another.

(9) In the case of any individual eighteen years of age or younger who is a ward of the state or any court and who

is placed in a county detention home established under section 43-2,110, the cost of his or her education shall be paid by the state, regardless of the district in which he or she resided at the time he or she became a ward, to the agency or institution which: (a) Is selected by the county board with jurisdiction over such detention home; (b) has agreed or contracted with such county board to provide educational services; and (c) has been approved by the State Department of Education pursuant to rules and regulations prescribed by the State Board of Education.

(10) No tuition shall be charged for students who may be by law allowed to attend the school without charge.

(11) On a form prescribed by the State Department of Education, an adult with legal or actual charge or control of a student shall provide the name of the student, the name of the adult with legal or actual charge or control of the student, the address where the student is residing, and the telephone number and address where the adult may generally be reached during the school day. If the student is homeless or if the adult does not have a telephone number and address where he or she may generally be reached during the school day, those parts of the form may be left blank and a box may be marked acknowledging that these are the reasons these parts of the form were left blank. The adult with legal or actual charge or control of the student shall also sign the form.

(12) The department shall adopt and promulgate rules and regulations to carry out the department's responsibilities under this section.

Sec. 88. Section 81-6,113, Reissue Revised Statutes of Nebraska, is amended to read:

81-6,113 For purposes of the Outpatient Surgical Procedures Data Act:

(1) Department means the Department of Health and Human Services Regulation and Licensure;

(2) Medicaid means the medical assistance program established ~~in section 68-1018~~ pursuant to the Medical Assistance Act;

(3) Medicare means Title XVIII of the federal Social Security Act, as such title existed on January 1, 2003;

(4) Outpatient surgical procedure means a surgical procedure provided to patients who do not require inpatient hospitalization;

(5) Primary payor means the public payor or private payor which is expected to be responsible for the largest percentage of the patient's current bill;

(6) Private payor means any nongovernmental source of funding; and

(7) Public payor means medicaid, medicare, and any other governmental source of funding.

Sec. 89. This act becomes operative on July 1, 2006.

Sec. 90. Original sections 28-705, 28-706, 43-512.12, 43-2508, 44-3,144, 44-3,149, 44-526, 44-32,180, 44-4221, 44-4222, 44-4228, 44-4726, 44-5305, 68-104, 68-150, 68-716, 68-1018, 68-1019, 68-1019.01, 68-1022, 68-1023, 68-1025.01, 68-1026, 68-1027, 68-1028, 68-1036.03, 68-1038, 68-1039, 68-1040, 68-1042,

68-1043, 68-1070, 68-1509, 71-6017.01, 71-7610, 71-8405, 71-8506, 77-908, 77-912, 77-27,163.01, 79-215, and 81-6,113, Reissue Revised Statutes of Nebraska, sections 25-21,188.02, 30-2487, 68-1036.02, 68-1073, 68-1074, 68-1075, 68-1076, 68-1077, 68-1078, 68-1079, 68-1080, 68-1081, 68-1082, 68-1083, 68-1084, 68-1085, 68-1086, 68-1802, 68-1803, 71-804, 71-806, 71-820, and 71-7607, Revised Statutes Cumulative Supplement, 2004, and sections 44-1540, 44-8002, 68-1020, 68-1021, 68-10,100, 68-10,101, 68-10,102, 68-10,103, 68-10,104, 68-10,105, 68-10,106, 68-10,107, 71-2426, and 77-2704.09, Revised Statutes Supplement, 2005, are repealed.

Sec. 91. The following sections are outright repealed: Sections 68-1019.02, 68-1019.03, 68-1019.04, 68-1019.05, 68-1019.06, 68-1019.09, 68-1024, 68-1025, 68-1029, 68-1030, 68-1031, 68-1033, 68-1034, 68-1035, 68-1035.01, 68-1036, 68-1049, 68-1050, 68-1051, 68-1056, 68-1057, 68-1058, 68-1059, 68-1060, 68-1061, 68-1062, 68-1063, 68-1067, 68-1068, 68-1069, 68-1071, 68-1072, and 83-1214, Reissue Revised Statutes of Nebraska, and sections 68-1021.01, 68-1037, 68-1048, 68-1087, 68-1088, 68-1089, 68-1090, 68-1091, 68-1092, 68-1093, 68-1094, 68-1095, 68-1096, 68-1097, 68-1098, and 68-1099, Revised Statutes Supplement, 2005.

Sec. 92. Since an emergency exists, this act takes effect when passed and approved according to law.

2. On page 1, line 2, after "44-3,144," insert "44-3,149,"; in line 5 after the second comma insert "68-1025.01,"; and in line 14 after "sections" insert "44-1540,".

3. On page 2, line 6, after the first semicolon insert "to eliminate the Managed Care Plan Act, the Medicaid Reform Act,

and the Long-Term Care Partnership Program Development Act;"; and in line 9 strike "68-1025.01,".